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State Department of Health

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CHAPTER 33-03-10

HOME HEALTH AGENCIES

[Repealed Effective January 1, 1998]

STAFF COMMENT. Chapter 33-03-10.1 contains all new material and is not underscored so as to improve readability.

CHAPTER 33-03-10.1
HOME HEALTH AGENCIES

33-03-10.1-01. Definitions. The following definitions, in addition to the definitions in North Dakota Century Code section 23-17.3-01, apply to this chapter:

1. "Agency" means home health agency.

2. "Branch" means a location or site from which a home health agency provides services within a portion of the total geographic area served by the parent agency. The branch office is part of the home health agency and is located close enough to share administration, supervision, and services.

3. "Clinical note" means a notation of a contact with a patient that is written and dated by a member of the health care team and that describes signs and symptoms, treatment and drugs administered and the patient's reaction, and any changes in physical or emotional condition.

4. "Companion services" includes staying or traveling with a patient and may include provision of guided maneuvering or nonweight bearing assistance.

5. "Department" means the state department of health.

6. "Governing body" means the individual or group in whom the ultimate authority and legal responsibility is vested for the conduct of the agency.

7. "Homemaker services" include preparing meals, shopping, assistance with bill paying, housework, laundry, transportation, communication, and mobility outside the patient's residence.

8. "Parent" means the agency office that develops and maintains administrative control of the branch offices.

9. "Progress notes" means a written notation, dated and signed by a member of the health care team, which summarizes facts about care furnished and the patient's response during a given period of time.

10. "Supervised practical training" means training in a laboratory or other setting in which the home health aide trainee demonstrates tasks on an individual under the direct supervision of a registered or licensed practical nurse.

History: Effective January 1, 1998.
General Authority: NDCC 23-01-04, 23-17.3-08
Law Implemented: NDCC 23-17.3-01, 23-17.3-08

33-03-10.1-02. Conflict with federal requirements. If any part of this chapter is found to conflict with federal requirements, the more stringent shall apply. Such a finding or determination shall be made by the department and shall not affect the remainder of this chapter.

History: Effective January 1, 1998.
General Authority: NDCC 23-01-04, 23-17.3-08
Law Implemented: NDCC 23-17.3-08

33-03-10.1-03. Application, issuance, and renewal of license. An entity meeting the definition of home health agency in North Dakota Century Code section 23-17.3-01 must obtain a license from the department to operate in North Dakota. A person or entity may not establish or operate an agency or use the terms home health agency or home health services without first having obtained a license.

1. Any person or entity who desires to maintain and operate an agency shall apply to the department for a license in the form prescribed and shall obtain an initial license before accepting patients for care or treatment.

   a. The department shall not approve an application for initial license unless:

(1) The application and all required attachments and statements submitted by the applicant meet the requirements of this chapter. A description of all services provided and the geographic areas to be served by agency staff must be included.

(2) The department has conducted an inspection or investigation of the agency to determine compliance with this chapter.

(3) The department has completed an investigation into the fitness of the applicant and determined the applicant to be fit based on the following:

(a) Evidence provided by the applicant which identifies that financial resources and sources of revenue for the applicant's agency appear adequate to provide the staff and services sufficient to comply with North Dakota Century Code chapter 23-17.3 and this chapter;

(b) The applicant has furnished the department with a signed and notarized statement describing and dating every proceeding, within five years of the date of application, in which the applicant was involved which resulted in a limitation, suspension, revocation, or refusal to grant or renew an agency license or a medicare or medicaid decertification action; and

(c) The applicant shall furnish a signed and notarized statement to the department describing every criminal proceeding within five years of the date of the application in which the licensee or any of its shareholders owning interest of five percent or more officers, directors, partners, or other controlling or managing persons, has been convicted or nolo contendere plea accepted, of a criminal offense related to the operation or ownership of an agency.

b. The initial license is valid for a period not to exceed one year and expires on December thirty-first of the year issued.

2. The department shall issue a renewal license when an agency is in compliance with the provisions of these licensing requirements, as determined by periodic unannounced onsite surveys conducted by the department and other information submitted by the agency upon the request of the department. Renewal licenses shall expire on December thirty-first of each year. The application for renewal must be received by the

department with sufficient time to process prior to the beginning of the licensure period.

3. In the case of an agency or operators of a preexisting agency which has had its license suspended or revoked or denied, the applicant shall submit with the request for relicensure sufficient justification to indicate the reasons for the suspension, revocation, or denial no longer exist, reasonable assurance that they will not recur, and evidence that all licensure requirements are met.

4. The department shall require an applicant or licensee to disclose the name, address, and official position of all persons who have a five percent or more ownership interest in the agency.

5. The department may issue a provisional license, valid for a specific period of time not to exceed ninety days. A provisional license may be issued when the department has determined there are one or more serious deficiencies or a pattern of repeat deficiencies related to compliance with these licensing requirements.

   a. A provisional license may be renewed at the discretion of the department, provided the licensee demonstrates to the department that it has made progress towards compliance and can effect compliance within the next ninety days. A provisional license may be renewed one time.

   b. When an agency operating under a provisional license notifies the department that it has corrected its deficiencies, the department will ascertain correction. Upon finding compliance, the department shall issue a renewal license.

6. When a subdivision of an agency, for example, the home care department of a hospital, applies for a license, the subdivision rather than the parent organization must be licensed as an agency and maintain records in such a way that subdivision activities and expenditures attributable to services provided are identifiable. The parent organization may determine who signs the agreement and other documents and receive and disburse funds.

7. If one or more branch offices are operated under the same management, the branch offices will be licensed under the parent agency's license.

8. Each license is valid only in the hands of the entity to whom it is issued and is not subject to sale, assignment, or other transfer, voluntary of involuntary, nor is a license valid for any agency other than those for which originally issued. The

license must be displayed in a conspicuous place within the agency.

9. The agency shall notify the department in writing at least thirty days in advance of any of the following changes:

   a. Transfer or change of ownership.

   b. Transfer of operating rights, including a lease of the agency where the lessor retains no control of the operation or management of the agency.

   c. Change in the name of the agency.

   d. A service is added or deleted.

   e. A change in the geographic area served.

10. The agency shall notify the department in writing within thirty days of a change in administrative staff as identified on the annual licensure application or the nurse executive.

11. Upon discontinuance of the operation or transfer of ownership of an agency, the license must be returned to the department.

12. Existing agencies subject to this chapter which are already in operation on January 1, 1998, will be given a reasonable time, not to exceed May 1, 1998, within which to comply with the rules, regulations, and standards provided for herein.

History: Effective January 1, 1998.
General Authority: NDCC 23-01-04, 23-17.3-02, 23-17.3-08
Law Implemented: NDCC 23-17.3-02, 23-17.3-04, 23-17.3-05, 23-17.3-08

33-03-10.1-04. Inspection by the department. The department may evaluate an agency's compliance with this chapter at any time through:

1. An announced or unannounced onsite review, including inspection and examination of all agency records and documents required by this chapter, interview with agency staff, and home visits with the patient's permission; or

2. A request for submission of written documentation verifying compliance.

History: Effective January 1, 1998.
General Authority: NDCC 23-01-04, 23-17.3-08
Law Implemented: NDCC 23-17.3-04, 23-17.3-08, 23-17.3-09

33-03-10.1-05. Plan of correction.

1. An agency shall submit to the department a plan of correction addressing the areas of noncompliance with the licensure requirements of this chapter.

2. A plan of correction must include:

   a. How the corrective action will be accomplished for those patients found to have been affected by the deficient practice;

   b. How the agency will identify other patients or services in the agency having the potential to be affected by the same deficient practice;

   c. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; and

   d. How the agency will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.

3. A plan of correction is required within ten calendar days of the receipt of the deficiency statement and is subject to acceptance, acceptance with revisions, or rejection by the department. Failure to submit an acceptable plan of correction may result in a directed plan of correction.

4. Corrections must be completed within sixty days of the survey completion date, unless an alternative schedule of correction has been specified by the department.

History: Effective January 1, 1998.
General Authority: NDCC 23-01-04, 23-17.3-08
Law Implemented: NDCC 23-17.3-04, 23-17.3-08

33-03-10.1-06. Enforcement.

1. Agencies are subject to one or more enforcement actions, which may include suspension or revocation of a license or a denial to license for the following reasons:

   a. Noncompliance with the licensure requirements in this chapter has been identified which:

      (1) Presents imminent danger to patients;

      (2) Has a direct or immediate relationship to the health, safety, or security of the agency's patients;

(3) If left uncorrected, has a potential for jeopardizing patient health or safety; or

(4) Is a recurrence of the same or substantially same violation in a twenty-four-month period.

b. Failure to correct any deficiency pursuant to a plan of correction or directed plan of correction, unless the department approves in writing an extension or modification of the plan of correction.

c. Gross incompetence, negligence, or misconduct in operating the agency as determined through department investigation or through a court of law.

d. Fraud, deceit, misrepresentation, or bribery in obtaining or attempting to obtain a license.

e. Lending, borrowing, or using the license of another agency.

f. Knowingly aiding or abetting in any way the improper granting of a license.

2. Conditions or practices that the department has determined to present imminent danger to patients receiving services from the agency must be abated or eliminated immediately or within a fixed period of time as specified by the department.

History: Effective January 1, 1998.
General Authority: NDCC 23-01-04, 23-17.3-08
Law Implemented: NDCC 23-17.3-07

33-03-10.1-07. Order and notice of order.

1. Upon a determination that the circumstances make imposition of a sanction appropriate, the department shall issue a written order identifying the violations and the sanction imposed. A copy of the order must be sent by registered mail, return receipt requested, to the agency's owner, the agency's administrator, or head of the agency's governing body. The order must specify the terms or conditions under which the sanction will be terminated. The order must also advise the agency of the right to seek reconsideration.

2. When an agency has been subjected to a sanction, the department may notify, as appropriate, applicable professional licensing agencies, boards of registration or licensure, and federal, state, or county agencies of the circumstances and sanctions imposed.

3. When an agency has been subjected to a sanction, the department shall notify the county social service board of each county where the agency provides services. Each county social service board so notified shall post, in a prominent place within the office, the name and address of the agency and the sanction. The posting must remain in place for the entire period of any sanction other than closure or termination from the program and for the first ninety days of closure or termination.

4. When an agency has been subjected to a sanction, the agency shall place notices of the sanction, supplied by the department at all agency entrances and exits. The department may also require the agency to purchase space in the print media to achieve public dissemination of information concerning any sanction.

History: Effective January 1, 1998.
General Authority: NDCC 23-01-04, 23-17.3-08
Law Implemented: NDCC 23-17.3-07, 23-17.3-08

33-03-10.1-08. Request for reconsideration.

1. Within ten days after receipt of the order, the agency may request reconsideration by the department. Within fifteen days after receipt of a request for reconsideration, the department shall grant or deny the request for reconsideration and may suspend the imposition of any sanction pending the decision on the reconsideration.

2. A request for reconsideration, in any event, must be denied unless it identifies, with specificity, each disputed violation and states the factual basis for its contention that the violation was erroneously determined. The correction of the factors that led to the determination of a violation may not be asserted as a basis for reconsideration.

3. If the department denies the request for reconsideration, the department shall notify the agency in writing of that decision. If the denial was for any reason other than a failure of the request to conform to the requirements of subsection 2, the notice must advise the agency of the right to appeal.

4. If the department determines to undertake the reconsideration, the decision on reconsideration must be rendered within forty days after the issuance of the order. The notice of the decision on reconsideration must advise the agency of the right to appeal.

5. If the agency fails to file a timely request for reconsideration which conforms to the requirements of

subsection 2, the order is final in all respects, and no further administrative or judicial review is applicable.

History: Effective January 1, 1998.
General Authority: NDCC 23-01-04, 23-17.3-08
Law Implemented: NDCC 23-17.3-07, 23-17.3-08

33-03-10.1-09. Appeals.

1. An agency dissatisfied with a decision on a timely request for reconsideration, which conforms to the requirements of subsection 2 of section 33-03-10.1-08, may appeal. An appeal may be perfected by mailing or delivering the information described in subdivisions a through d, to the department, state capitol, Bismarck, North Dakota, so that the mailed or delivered material arrives at the office of the division of health facilities on or before 5:00 p.m. on the thirty-first day after the date of the determination the department made with respect to a request for reconsideration. An appeal under this section is perfected only if accompanied by written documents, including all of the following information:

   a. A copy of the notice received from the department advising of the department's decision on the request for reconsideration;

   b. A statement of each disputed violation and the reason or basis in fact for the dispute;

   c. The authority in statute or rule upon which the appealing party relies for each disputed item; and

   d. The name, address, and telephone number of the person upon whom all notices will be served regarding the appeal.

2. Except as otherwise provided in this section, the appeal must be considered as provided in article 98-02.

3. The dispositive issue on appeal must be whether the violation occurred, not whether the violation has been corrected.

4. The hearing officer must make written findings of fact and conclusions of law, and must recommend a decision to the department. The recommended decision must set forth the reasons for the decision and the evidence upon which the decision is based.

5. The department may accept, modify, or reject the recommended decision. If the department rejects the recommended decision, it may remand the matter to the office of administrative hearings with directions. The department, through its directions, may require the receipt of additional evidence,

and the submission of amended findings of fact, conclusions of law, and recommended decision which reflect consideration of additional evidence. The department, through its directions, may require that the matter be referred to the same or a different hearing officer and the office of administrative hearings shall comply with that direction unless compliance is impossible.

6. An appeal may not suspend or delay the imposition of a remedy under this chapter.

History: Effective January 1, 1998.
General Authority: NDCC 23-01-04, 23-17.3-08
Law Implemented: NDCC 23-17.3-07, 23-17.3-08

33-03-10.1-10. Governing body. The governing body is legally responsible for the quality of patient care services; for patient safety and security; for the conduct, operation, and obligations of the agency; and for ensuring compliance with all federal, state, and local laws. Contracts, arrangements, or other agreements may not limit the responsibility of the governing body in any way. The governing body shall:

1. Have bylaws or the equivalent, which shall be reviewed annually and be revised as needed. They must be made available to all members of the governing body. The bylaws or equivalent must specify the duties and responsibilities of the governing body.

2. Approve an overall plan and budget for the agency which includes an annual operating budget and capital expenditure plan.

3. Provide and maintain an office facility adequately equipped for efficient work and which provides a safe working environment in compliance with local ordinances and fire regulations.

4. Employ a qualified administrator who is designated in writing as administratively responsible and available for all aspects of agency operation including the employment of qualified staff, accuracy of public information, and implementation of the budget.

   a. A qualified administrator is:

      (1) A licensed physician, registered nurse, or college graduate with a bachelor's degree who has a minimum of three years of health care management; or

(2) A person without a college degree may qualify by obtaining the equivalent of six years of supervisory experience in health care management.

b. The administrator and nurse executive may be the same individual if the individual is dually qualified.

c. The administrator must identify in writing an individual who is qualified and authorized to act in place of the administrator when the administrator is not available.

5. Organize agency services to ensure quality of patient care. An organizational chart, from the governing body to the patients, with a written description of the organization, authorities, responsibilities, accountabilities, and relationships must be maintained which must include:

a. A description of each service offered;

b. Policies and procedures pertaining to each service;

c. Job descriptions for each discipline; and

d. A description of the system for maintenance of patient records.

6. Ensure the development, implementation, review and revision of policies and procedures as changes in standards of practice occur. All policies and procedures must be reviewed at a minimum of every three years and must include the following:

a. Operation and administration of the agency, including:

(1) Provision of therapeutic and supportive services under the direction of a physician or registered nurse.

(2) Acceptance of only patients for whom they can provide the needed services. Acceptance is based on medical, nursing, and social information provided by the patient's physician, the facility the patient is being discharged from, and the staff of the agency, as applicable.

(3) Provision of services to patients consistent with the treatment plan established, signed, and regularly reviewed by the physician responsible for the patient's care. Supportive services may be provided, without a physician's order, consistent with the care plan established, signed, and regularly reviewed by the registered nurse when therapeutic services are not needed by the patient.

(4) When therapeutic services are ordered, the total plan of care shall be reviewed by the patient's physician at such intervals as the patient's condition requires, but no less than once every two months. Verbal authorization to change the plan of treatment shall be reviewed and signed by the physician consistent with agency policy.

(5) Availability of services to patients regardless of age, sex, religion, or ethnic background.

(6) Clinical records that are accurate, concise, and consistent with current medical records standards of practice must be maintained for each patient which cover the services the agency provides directly or through arrangement, and contain pertinent past and current medical, nursing, and social information including the plan of treatment and care.

(7) A means to ensure all records must be maintained in a confidential manner.

(8) A means to report, investigate, and document action taken on grievances, including follow-through with the patient or the patient's family.

b. Personnel records that include the following documentation:

(1) Checking of state registries and licensure boards prior to employment for findings of inappropriate conduct, employment, disciplinary actions, and termination;

(2) Job descriptions;

(3) Orientation records;

(4) Training and education records;

(5) Disciplinary action records;

(6) Verification of current licensure or registration status, if applicable;

(7) Documentation of annual performance reviews; and

(8) Documentation of competency evaluation of home health aides, at a minimum, every two years.

c. Notification of each patient in writing of the patient's rights during the initial evaluation visit prior to the

initiation of treatment. Patient rights, at a minimum, include the right to:

(1) Be given care without discrimination as to race, color, creed, sex, age, or national origin.

(2) Exercise the person's right as a patient of the agency. If the patient has been judged incompetent, the patient's family or guardian may exercise the patient's rights.

(3) Choose care providers and the right to communicate with those providers.

(4) Be fully informed of the patient's medical condition and to have access to the patient's medical record.

(5) Be informed, in advance, about the care to be furnished and any changes in the care to be furnished, the disciplines that will furnish the care, the frequency of visits proposed, any changes in the plan of care before the change is made, and of the patient's right to participate in planning the care and planning any changes in the care.

(6) Refuse care and to be informed of possible health consequences of this action.

(7) Be provided information regarding advanced directives prior to the initiation of treatment.

(8) Be informed of the need for transfer, referral, or discharge from the agency.

(9) Be treated with dignity, privacy, respect, and consideration as well as freedom from abuse, neglect, or misappropriation of the patient's property.

(10) Voice grievances regarding treatment or care that is, or fails to be, furnished or regarding lack of respect for property by anyone who is furnishing services on behalf of the agency and to not be subjected to discrimination or reprisal for doing so.

(11) Confidentiality regarding the patient's medical condition and medical records.

(12) Advise, before care is initiated, of the extent to which payment for agency services may be expected from Medicare, Medicaid, or other sources and the extent to which payment may be required from the patient. The patient must also be informed orally and in writing of any changes in payment sources no

later than thirty calendar days after the agency becomes aware of the changes.

(13) Use of the toll-free hotline established by the department to receive complaints or questions about local agencies and the hours of operation of the hotline.

7. Ensure there is a written agreement or contract in place and signed by both parties when arranging for services from individuals not employed directly by the agency or from other agencies.

   a. The written agreement or contract must at a minimum state the following:

      (1) Patients may be accepted for care only by the agency;

      (2) The specific service to be provided;

      (3) The period of time the contract is in effect;

      (4) The availability of the service;

      (5) Financial arrangements;

      (6) Verification that any individual providing service is appropriately licensed or registered as required by state statute or regulation;

      (7) Provisions for supervision of contract personnel where applicable;

      (8) Assurance that individuals providing services under contractual arrangements meet the same requirements as those specified for agency personnel;

      (9) Provision for the documentation of services rendered in the patient's record;

      (10) Provision for the sharing of assessment and plan of care data;

      (11) The geographic area the contractor agrees to serve;

      (12) Specify that only the contracting agency shall bill for services provided under the written agreements and collect the applicable payments pertaining to the contracted services; and

      (13) Evaluation of the acceptability of the contracted services.

b. All contract services must be provided in accordance with the patient's plan of care.

c. The agency shall assure that all contract services are provided in accordance with the agreement. Agreements must be reviewed on an annual basis and updated as necessary.

d. The agency that is subcontracting its work must maintain or produce a complete home care record for each patient.

8. Ensure the agency obtains and maintains compliance with the applicable parts of the clinical laboratory improvement amendments of 1988, 42 CFR part 493, if the agency provides any laboratory testing service, regardless of the frequency or the complexity of the testing.

9. Meet with agency administrative staff to review the operation of the agency at a frequency sufficient to ensure safe and effective patient care.

10. Keep minutes of all meetings including actions taken.

History: Effective January 1, 1998.
General Authority: NDCC 23-01-04, 23-17.3-08
Law Implemented: NDCC 23-17.3-05, 23-17.3-08

33-03-10.1-11. Quality improvement and program evaluation.

1. The agency shall develop, implement, and document an ongoing agencywide quality improvement program to monitor, evaluate, and improve the quality of patient care, administrative, and support services, including all contracted services, and to ensure services are provided in compliance with professional standards of practice.

   a. The quality improvement program must include a written plan that identifies a mechanism to identify problems, recommend appropriate action, implement recommendations, and monitor results.

   b. Each quarter a sample of active and closed clinical records must be reviewed, by a group of appropriate professionals representing the home health services provided during the previous quarter, to determine whether established policies are followed in furnishing services directly or through contract. This review must be documented as a part of the quality improvement program.

   c. The clinical records for all patients must be reviewed each sixty-two-day period to determine adequacy of the

plan of treatment and the appropriateness of continuance of care.

d. The administrator shall maintain a record of the activities of the quality improvement program and ensure findings, conclusions, and recommendations are reported to the governing body.

2. The agency shall complete an overall evaluation of its program annually and documentation of the reviews must be maintained as a part of the administrative records. The evaluation must, at a minimum, include an overall policy review, administrative review, and a clinical record review.

History: Effective January 1, 1998.
General Authority: NDCC 23-01-04, 23-17.3-08
Law Implemented: NDCC 23-17.3-05, 23-17.3-08

33-03-10.1-12. Education programs. The agency shall design, implement, and document educational programs to orient new employees and keep all staff current on new and expanding programs, therapeutic services, techniques, equipment, and concepts of quality care.

1. The following topics must be covered with all staff annually:

   a. Prevention and control of infections, including universal precautions;

   b. Patient rights; and

   c. Safety and emergency procedures.

2. In addition to meeting the training and competency evaluation or competency evaluation requirements in section 33-03-10.1-18, individuals providing home health aide services must receive twelve hours of inservice education within a twelve-month period.

   a. This inservice education may occur while the aide is furnishing care to the patient.

   b. Inservice training must be supervised by a registered nurse with a minimum of two years' experience, one of which is in the provision of home health services.

History: Effective January 1, 1998.
General Authority: NDCC 23-01-04, 23-17.3-08
Law Implemented: NDCC 23-17.3-05, 23-17.3-08

33-03-10.1-13. Medical services.

1. All therapeutic services delivered to the patient by the agency must be approved by the patient's physician, including frequency and duration of services.

2. All therapeutic services must be provided consistent with a written treatment plan established and periodically reviewed by the patient's physician and must include at least the following:

   a. Orders for home health services, including orders for:

      (1) Skilled nursing, home health aide services, or other therapeutic services;

      (2) Medical supplies and equipment;

      (3) Medications and treatments when applicable;

      (4) Special dietary or nutritional needs when applicable; and

      (5) Medical tests including laboratory tests and x-rays when applicable.

   b. Diagnosis and prognosis.

   c. Functional limitations.

History: Effective January 1, 1998.
General Authority: NDCC 23-01-04, 23-17.3-08
Law Implemented: NDCC 23-17.3-05, 23-17.3-08

33-03-10.1-14. Nursing services.

1. Skilled nursing services must be provided under the direction of a nurse executive (director of nursing) who is a registered nurse licensed to practice in North Dakota, with at least one year's full-time experience in providing direct patient care in a home health setting and three years' experience as a registered nurse. The nurse executive must have written administrative authority, responsibility, and accountability for the integration and coordination of nursing services consistent with the overall agency organization and plan for patient care. The nurse executive shall:

   a. Be a full-time, salaried employee of the agency;

   b. Supervise all patient care activities to assure compliance with current standards of accepted nursing and medical practice;

c. Develop, maintain, periodically review, and cause to implement philosophy, objectives, standards of practice, policies and procedures, and job descriptions for each level of nursing service personnel;

d. Ensure there are sufficient qualified nursing personnel to meet the nursing care needs of the patients in accordance with the plan of care;

e. Ensure there is a registered nurse available by telephone during operating hours and when home health services are being provided to receive referrals, orders, patient phone calls, and any other concerns that may arise; and

f. Identify an alternate registered nurse in writing to function as the nurse executive when the nurse executive is not available.

2. A registered nurse shall:

a. Make the initial evaluation visit, initiate the plan of care, regularly reevaluate the patients' nursing needs, and make necessary revisions to the plan of care.

(1) If the patient receives skilled nursing services and home health aide services, the registered nurse must make supervisory visits no less frequently than every two weeks.

(2) If the patient is not receiving skilled nursing services, but is receiving home health aide, homemaker, or companion services, the registered nurse must make contact at least every sixty-two days to determine the appropriateness of the plan of care and the acceptability of the care provided.

b. Initiate preventive and rehabilitative nursing procedures, prepare clinical notes, coordinate therapeutic and supportive services, inform the physician and other personnel of changes in the patient's condition and needs, and counsel the patient and family regarding patient care needs.

c. Assign home health aides to specific patients dependent upon the needs of the patient and the skill of the home health aide.

d. Participate in inservice programs, supervise and teach other nursing personnel.

3. Licensed practical nurses shall furnish patient care services in accordance with agency policies, prepare clinical and

progress notes, and assist the physician and registered nurse in performing specialized procedures and patient teaching.

4. If home health aide services are provided, either directly or by contract, the services must be provided by individuals who meet the training and competency or competency requirements specified in section 33-03-10.1-18 and meet registry requirements as specified by state statute. Individuals providing home health aide services shall:

   a. Be supervised by a registered nurse; and

   b. Provide patient care and services that home health aides are permitted to provide by state statute and rules which are consistent with the physician's orders, assigned by the registered nurse for a specific patient, contained in the patient's plan of care and written instructions from the registered nurse or other appropriate professionals, and agency policies and procedures.

History: Effective January 1, 1998.
General Authority: NDCC 23-01-04, 23-17.3-08
Law Implemented: NDCC 23-17.3-05, 23-17.3-08

33-03-10.1-15. Patient plan of care. A written plan of care must be developed for each patient which must include reference to at least the following:

1. All pertinent diagnoses;

2. Prognosis, including short-term and long-term objectives of care;

3. Types and frequency of services to be provided, including medication, diet, treatment procedures, equipment, and devices;

4. Functional limitations of the patient;

5. Activities permitted;

6. Safety measures required to protect the patient from injury; and

7. Sociopsychological needs of the patient.

History: Effective January 1, 1998.
General Authority: NDCC 23-01-04, 23-17.3-08
Law Implemented: NDCC 23-17.3-05, 23-17.3-08

33-03-10.1-16. Clinical record services. An agency shall maintain clinical records for each patient and provide relevant information from these clinical records to the personnel providing services in the patient's home.

1. The clinical record must contain sufficient information to identify the patient clearly, to justify the diagnosis and treatment, and to document the results of treatment accurately. All clinical records must contain at least the following general categories of data:

   a. Identification data and consent forms;

   b. The name, address, and phone number of the patient's physician;

   c. The physician's signed order for therapeutic services and the approved plan of care, which must include, when appropriate to the services being provided:

      (1) Medical diagnosis;

      (2) Medication orders;

      (3) Dietary orders;

      (4) Treatment orders;

      (5) Activity orders; and

      (6) Safety orders.

   d. Initial and periodic assessments and care plans by professionals providing services;

   e. Signed and dated admission, observation, progress, clinical and supervisory notes, and other information necessary to document services are provided and not just offered;

   f. Copies of summary reports sent to the physician;

   g. Diagnostic and therapeutic orders signed by the physician;

   h. Reports of treatment and clinical findings;

   i. Transfer form, if applicable; and

   j. Discharge summary.

2. All clinical information pertaining to the patient's care must be maintained in a centralized location by the parent or branch office.

3. Clinical records of services provided must be kept in ink, typed, or electronic data systems.

4. Entries into the clinical record for services rendered must be written within twenty-four hours and incorporated into the clinical record in a timeframe specified by agency policy.

5. Entries must be made by the person providing services, must contain a statement of facts personally observed, and must be signed and dated. Initials may be used in the clinical record if the full name has been identified in another location in the record.

6. Verbal orders from a physician must be signed and incorporated into the clinical record in a timeframe consistent with agency policy.

7. Clinical records must be safeguarded against loss or unauthorized use. Written policies and procedures must be in place regarding the use and removal of records and the conditions for release of information. The patient's or legal representative's written consent must be required for release of information not authorized by statute.

8. Clinical records must be maintained consistent with acceptable professional guidelines.

9. Retention of patient records must be as follows:

   a. Patient records of discharged patients must be preserved for a period of ten years from the date of discharge. Records of deceased patients must be preserved seven years.

   b. In the case of minors, records must be retained for the period of minority and ten years from the date of live discharge. Records of deceased patients who are minors must be preserved for the period of minority and seven years.

History: Effective January 1, 1998.
General Authority: NDCC 23-01-04, 23-17.3-08
Law Implemented: NDCC 23-17.3-05, 23-17.3-08

33-03-10.1-17. Therapeutic services. Any therapeutic service provided by the agency, either directly or by contract, must be provided by individuals qualified consistent with state law to provide the therapeutic service. Individuals providing therapeutic services shall:

1. Provide treatments in accordance with the scope of practice for their profession.

2. Assess the needs of the patient, prepare a plan of care based on the assessment, and provide services to the patient as specified in the plan of care, reassessing the patient's response to services provided and revising a plan of care as needed.

3. Prepare clinical and progress notes to be included in the clinical record.

4. Participate in and document all care planning, care conferences, and quality improvement activities.

5. Act as a consultant to other agency personnel.

6. Work with the family.

7. Teach and supervise other health personnel when appropriate.

History: Effective January 1, 1998.
General Authority: NDCC 23-01-04, 23-17.3-08
Law Implemented: NDCC 23-17.3-01, 23-17.3-05, 23-17.3-08

33-03-10.1-18. Home health aide training and competency evaluation. Any individual employed by an agency to provide home health aide services directly or by contract must complete a nurse aide training and competency evaluation program or a competency evaluation program which meets the following:

1. The training program must total at least seventy-five clock hours, with at least sixteen of the seventy-five hours being devoted to classroom training prior to initiating the supervised practical training. At least sixteen hours of the total program hours must be devoted to supervised practical training.

   a. The training, including supervised practical training, of home health aides must be performed under the general supervision of a registered nurse who possesses a minimum of two years of nursing experience, at least one year of which must be in the provision of home health care services. Other professionals may be used to provide instruction under the supervision of the qualified registered nurse.

   b. The training program must, at a minimum, include the following topics:

      (1) Communication skills;

      (2) Observation, reporting, and documentation of patient status and care or services furnished;

(3) Reading and recording of temperature, pulse, and respiration;

(4) Basic infection control procedures;

(5) Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor;

(6) Maintenance of a clean, safe, and healthy environment;

(7) Recognizing emergencies and knowledge of emergency procedures;

(8) The physical, emotional, and developmental needs of and ways to work with the patients served;

(9) Patient rights;

(10) Appropriate and safe techniques in personal hygiene and grooming which include:

(a) Bed bath;

(b) Sponge, tub, or shower bath;

(c) Shampoo, sink, tub, or bed;

(d) Oral hygiene; and

(e) Nail or skin care.

(11) Safe transfer techniques and ambulation;

(12) Normal range of motion and positioning;

(13) Adequate nutrition and fluid intake; and

(14) Any other tasks the agency may choose to have the home health aide perform.

c. The agency must maintain sufficient documentation to demonstrate that the requirements for the training of home health aides of this section are met.

d. Agencies that have had state or federal enforcement action, other than the citation of deficiencies, filed against them in the past two years are not eligible to operate a home health aide training program.

2. An individual may provide home health aide services on behalf of the agency only after that individual has successfully

completed a competency evaluation that consists of the following:

a. The competency evaluation must be conducted by a registered nurse.

b. The competency evaluation must address each of the items listed in subdivision b of subsection 1.

   (1) The items listed in paragraphs 3, 10, 11, and 12 of subdivision b of subsection 1 must be completed by observation of the aide's performance of the tasks with a patient or other live individual.

   (2) All other items listed in subdivision b of subsection 1 can be evaluated through written or oral examination or observation of the aide with a patient.

c. A home health aide is not considered to have successfully passed a competency evaluation program if the aide has an unsatisfactory rating in more than one of the required areas.

   (1) A home health aide cannot perform any task for which the aide is evaluated to perform unsatisfactorily unless under the direct supervision of a licensed nurse.

   (2) The home health aide must receive training in the areas determined unsatisfactory and pass a subsequent evaluation satisfactorily prior to performing the task without supervision.

d. The agency must maintain documentation that the competency evaluation requirements of this section have been met by each home health aide.

History: Effective January 1, 1998.
General Authority: NDCC 23-01-04, 23-17.3-08
Law Implemented: NDCC 23-17.3-05, 23-17.3-08

CHAPTER 33-06-05

33-06-05-01. Requirements.

1. **Definitions.** As used in this section:

   a. "Age-appropriate" refers to the vaccines a child should receive based on age and previous immunization history as recommended by the advisory committee of immunization practices and outlined by the North Dakota immunization schedule.

   b. "Beliefs" as used in subsection 3 of North Dakota Century Code section 23-07-17.1 means sincerely held religious beliefs which are not a pretense for avoiding legal requirements and does not include secular beliefs such as those beliefs based upon philosophy or science.

   c. "Institution" includes all ~~day-care-and-child-care~~ early childhood facilities, head start programs, ~~nursery-schools~~ preschool education facilities, public and private kindergartens, and elementary and high schools operating in North Dakota.

   ~~b.~~ d. "Institution authority" means anyone designated by the governing body of an institution.

2. **Minimum requirements.**

   a. Minimum requirements for children attending ~~day-care-and child--care~~ early childhood facilities, head start programs, and ~~nursery---schools~~ preschool education facilities shall be ~~three~~ age-appropriate inoculations ~~of~~ against diphtheria, pertussis, ~~and~~ tetanus ~~vaccine, three doses-of-oral~~ poliomyelitis ~~vaccine, and-one-dose-each--of~~ measles, mumps, and rubella ~~(MMR)-vaccine-if-given-after fifteen-months-of-age~~. Each child must also be adequately immunized for Haemophilus influenzae type b disease at the age-appropriate schedule recommended by the state department of health ~~and-consolidated-laboratories-with-a vaccine-approved--by--the--food--and--drug--administration (FDA)~~.

   b. Minimum requirements for children attending kindergartens and elementary and high schools shall be ~~four~~ age-appropriate inoculations ~~of~~ against diphtheria, pertussis, ~~and~~ tetanus ~~vaccine, four--doses--of---oral~~ poliomyelitis ~~vaccine, and--one--dose--each--of~~ measles, mumps, and rubella ~~(MMR)-vaccine-if--given--after--fifteen months--of--age~~. A second dose of measles, mumps, and rubella (MMR) vaccine is required ~~for~~ age-appropriately at

school entry into kindergarten or first grade or seventh grade.

c. Exception to these minimum requirements for those children who ~~do-not-start-immunizations-at-the-recommended-time~~ are not age-appropriately immunized shall be determined by ~~an authorized--representative--of--the--state--department--of health--and--consolidated--laboratories~~ the state health officer or state health officer's designee.

3. **Recordkeeping and reporting.** Records and reports ~~prescribed~~ requested by the state department of health ~~and--consolidated laboratories~~ shall be completed and submitted ~~in-accordance with-instructions-on-the--forms--furnished--by~~ to the state department of health ~~and-consolidated-laboratories~~.

a. Certificates of immunization or other official proof of immunization must be presented to the designated institution authority before any child is admitted to an institution. ~~The-original~~ Proof of immunization must be maintained ~~in~~ by the child's school ~~record~~ or early childhood facility. ~~The-copy--must--be--retained--by--the parent-or-guardian.~~ An appropriately signed certificate of immunization must be presented to the designated institution authority for medical or "belief" exemptions.

b. The school or early childhood facility immunization summary report ~~and-the-record--of--inadequately--immunized children~~ must be submitted to the state department of health ~~and-consolidated-laboratories~~ by October first of each year.

4. **Appointment of an institution authority.**

a. An institution authority shall be appointed for each institution by its governing board or authorized personnel. ~~He--or--she--shall~~ The authority must be an employee of such institution.

b. The name of the designated institution authority, the institution, address, and telephone number shall be submitted to the appropriate governing state department ~~of health---and---consolidated---laboratories,---immunization division,~~ by July first of each year.

5. ~~Children--admitted--to--school--in--the--process--of-receiving immunizations.~~ Any child admitted to school or early childhood facility under the provision that such child is in the process of receiving the required immunizations shall be required to receive the immunizations according to the recommended schedule set forth by the state department of health ~~and-consolidated-laboratories~~. Any child not adhering to the recommended schedule shall ~~be-promptly~~ provide proof of

immunization or a certificate of immunization within thirty days of enrollment or be excluded from school or early childhood facility.

History: Amended effective November 1, 1979; September 1, 1991; January 1, 1998.
General Authority: NDCC 23-01-03
Law Implemented: NDCC 23-07-17.1

TITLE 43

Industrial Commission

DECEMBER 1997

CHAPTER 43-02-03

43-02-03-52. Report of oil production. The operator of each well in every pool shall, on or before the first day of the second month succeeding the month in which production occurs, file with the director a sworn statement showing the amount of production made by each such well upon forms furnished therefor, or approved computer sheets no larger than eight and one-half by fourteen inches [21.59 by 35.56 centimeters]. In lieu of a notarized report, an operator may submit to the commission a list of persons authorized to sign the monthly oil production report. The commission will accept a report signed by any person on the list provided that person's signature is witnessed. Wells for which reports of production are not received by the close of business on said first day of the month shall be shut in for a period not to exceed thirty days. The director shall notify, by certified mail, the operator and authorized transporter of the shut-in period for such wells. Any oil produced during such shut-in period shall be deemed illegal oil and subject to the provisions of North Dakota Century Code section 38-08-15.

History: Amended effective April 30, 1981; January 1, 1983; May 1, 1992; December 1, 1997.
General Authority: NDCC 38-08-04
Law Implemented: NDCC 38-08-04

43-02-03-52.1. Report of gas produced in association with oil. The operator of each well in every pool shall, on or before the fifth day of the second month succeeding the month in which production occurs, file with the director a sworn statement showing the amount of gas produced by each such well upon forms furnished therefor, or approved computer sheets. In lieu of a notarized report, an operator may submit

to the commission a list of persons authorized to sign the monthly gas production report. The commission will accept a report signed by any person on the list provided that person's signature is witnessed. Wells for which reports of production are not received by the close of business on said fifth day of the month must be shut in for a period not to exceed thirty days. The director shall notify, by certified mail, the operator and authorized transporter of the shut-in period for such wells. Any gas produced during such shut-in period must be deemed illegal gas and subject to the provisions of North Dakota Century Code section 38-08-15.

History: Effective May 1, 1992; amended effective December 1, 1997.
General Authority: NDCC 38-08-04
Law Implemented: NDCC 38-08-04

STAFF COMMENT: Chapter 43-02-12 contains all new material but is not underscored so as to improve readability.

CHAPTER 43-02-12
GEOPHYSICAL EXPLORATION REQUIREMENTS

43-02-12-01. Definitions. The terms used in this chapter have the same meaning as in North Dakota Century Code chapter 38-08.1. As used in this chapter, "building" means any residence or commercial structure including a barn, stable, or other similar structure, and "operator of the land" means the surface owner or the surface owner's tenant of the land upon which geophysical operations are to be conducted.

History: Effective December 1, 1997.
General Authority: NDCC 38-08.1
Law Implemented: NDCC 38-08.1-01

43-02-12-02. Certification to do business within state - Resident agent. Any person desiring to engage in geophysical exploration within this state, including a contractor or subcontractor, shall obtain from the secretary of state a certificate of authority to transact business in this state. A copy of this certificate must be filed with the commission prior to, or together with, the bond required herein and the application for permit to engage in geophysical exploration.

History: Effective December 1, 1997.
General Authority: NDCC 38-08.1
Law Implemented: NDCC 38-08.1-03

43-02-12-03. Bonding requirements.

1. To satisfy the obligation that a geophysical exploration contractor desiring to engage in geophysical exploration shall file with the commission a good and sufficient surety bond,

the contractor, in lieu of a surety bond, may post cash or a certificate of deposit with the Bank of North Dakota. Persons desiring to file a cash bond or certificate of deposit shall file with the commission an application to deposit cash or certificate of deposit. If the applicant is currently in compliance with the statutes, rules, and orders of the commission, the commission will issue to the Bank of North Dakota a compliance statement authorizing the Bank of North Dakota to accept cash or a certificate of deposit as a bond for the applicant.

2. Geophysical exploration contractors shall file with the commission a good and sufficient bond in the amount of fifty thousand dollars if the contractor intends to conduct shot hole operations or in the amount of twenty-five thousand dollars if the contractor intends to use any other method of geophysical exploration. Each subcontractor engaged by the geophysical exploration contractor for the drilling and plugging of seismic shot holes shall file with the commission a good and sufficient bond in the amount of ten thousand dollars.

History: Effective December 1, 1997.
General Authority: NDCC 38-08.1
Law Implemented: NDCC 38-08.1-03.1

43-02-12-04. Exploration permit - Application.

1. Any person applying to the commission for an exploration permit must have a certificate to conduct geophysical exploration pursuant to subsection 3 of North Dakota Century Code section 38-08.1-03.1. A person may not commence geophysical exploration activities in this state without first obtaining an exploration permit from the commission. An application for an exploration permit must include the following:

   a. The name, permanent address, and telephone number of the geophysical contractor and the geophysical contractor's local representative.

   b. The name, permanent address, and telephone number of the drilling and hole plugging contractor, if different from the seismic contractor.

   c. The name and address of the resident agent for service of process of the person intending to engage in geophysical exploration.

   d. The bond number, type, and amount for the geophysical company.

e. The geophysical exploration method (i.e., shot hole, nonexplosive, 2D, 3D).

f. The number, depth, and location of the seismic holes and the size of the explosive charges, if applicable.

g. The anticipated starting date of seismic and plugging operations.

h. The anticipated completion date of seismic and plugging operations.

i. A description of hole plugging procedures.

j. A description of the identifying marks that will be on the hat or nonmetallic plug to be used in the plugging of the seismic hole.

k. A preplot map displaying the proposed seismic project lines and shot hole locations.

l. A fee of one hundred dollars.

2. The permitholder shall notify the commission at least twenty-four hours, excluding Saturdays and holidays, before commencing geophysical activity.

History: Effective December 1, 1997.
General Authority: NDCC 38-08.1
Law Implemented: NDCC 38-08.1-04.1

43-02-12-05. Distance restrictions - Shot hole operations - Nonexplosive methods. Seismic shot hole operations may not be conducted less than one thousand three hundred twenty feet [402.34 meters] from water wells, buildings, underground cisterns, pipelines, and flowing springs.

Nonexplosive exploration methods may not be conducted less than three hundred feet [91.44 meters] from water wells, buildings, underground cisterns, pipelines, and flowing springs.

Variances may be granted to this section by written agreement between the permitholder and the operator of the land and must be available to the commission upon request.

History: Effective December 1, 1997.
General Authority: NDCC 38-08.1
Law Implemented: NDCC 38-08.1-08

43-02-12-06. Notification of work performed. Within thirty days following the completion of geophysical exploration by any person within

this state, such person shall file with the commission a seismic completion report in the form of an affidavit deposing that the seismic project was completed in accordance with chapter 43-02-12, and incorporating a postplot map displaying the actual shot point location and the location of all undetonated (loaded) holes.

Any person plugging a seismic hole must submit a plugging report and an affidavit of plugging detailing the line number, shot point number, hole depth, drill type, hole condition (wet, dry), bentonite used (sacks, capsules), and the depth at which the surface plug was set, and all other information necessary to describe the conditions of the shot hole.

History: Effective December 1, 1997.
General Authority: NDCC 38-08.1
Law Implemented: NDCC 38-08.1-02, 38-08.1-05

43-02-12-07. Drilling and plugging requirements.

1. Prior to commencement of any drilling or plugging operations, the commission may require a field meeting with the geophysical contractor and subcontractors.

2. Except in those circumstances in which the commission allows otherwise, all seismic shot holes must be plugged the same day as they were drilled and loaded. Any blown out shot holes must be plugged as soon as reasonably practicable, unless, upon application, the commission grants an extension which may not exceed ninety days. All seismic shot holes must be temporarily capped until final plugging.

3. If the number of drilling rigs on a proposed project exceeds the commission's capacity to provide appropriate inspection, the commission may limit the number of drilling rigs.

4. Bentonite materials used in seismic hole plugging must be derived from naturally occurring untreated, high swelling sodium bentonite which consists principally of the mineral montmorillonite.

5. A durable nonrusting metal or plastic tag must be set at a depth of approximately three feet [91.44 centimeters] below the surface of every shot hole and shall be imprinted with the name of the operator responsible for the plugging and its permit number.

6. Unless the contractor can prove to the satisfaction of the commission that another method will provide better protection to ground water and long-term land stability, seismic shot hole plugging shall be conducted in the following manner:

a. When water is used in conjunction with the drilling of seismic shot holes or when water is encountered in the hole, the shot holes are to be filled with coarse ground bentonite approximately three-fourths of one inch [19.05 millimeters] in diameter from the top of the charge up to a depth above the final water level. Cuttings shall be added from the top of the bentonite to the surface. All cuttings added above the nonmetallic plug shall be tamped.

b. When drilling with air only, and in completely dry holes, a plugging may be accomplished by returning the cuttings to the hole. A small mound must be left over the hole for settling allowance.

c. Any drilling fluid or cuttings which are deposited on the surface around the seismic hole will be spread out in such a manner that the growth of natural grasses or foliage will not be impaired.

d. The existing cap leads must be cut off below ground level.

History: Effective December 1, 1997.
General Authority: NDCC 38-08.1
Law Implemented: NDCC 38-08.1-02, 38-08.1-06, 38-08.1-06.1

TITLE 45

Insurance, Commissioner of

JANUARY 1998

CHAPTER 45-06-01.1

45-06-01.1-01. Applicability and scope.

1. Except as otherwise specifically provided in sections 45-06-01.1-05, 45-06-01.1-10, 45-06-01.1-11, 45-06-01.1-14, and 45-06-01.1-19, this chapter applies to:

   a. All medicare supplement policies delivered or issued for delivery in this state on or after the effective date ~~hereof~~ of this rule; and

   b. All certificates issued under group medicare supplement policies which certificates have been delivered or issued for delivery in this state.

2. This chapter does not apply to a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

History: Effective January 1, 1992; amended effective July 8, 1997.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1

45-06-01.1-03. Policy definitions and terms. No policy or certificate may be advertised, solicited, or issued for delivery in this state as a medicare supplement policy or certificate unless such policy

or certificate contains definitions or terms which conform to the requirements of this section.

1. "Accident", "accidental injury", or "accidental means" must be defined to employ "result" language and may not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

   a. The definition may not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force".

   b. ~~Such~~ The definition may provide that injuries do not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

2. "Benefit period" or "medicare benefit period" may not be defined more restrictively than as defined in the medicare program.

3. "Convalescent nursing home", "extended care facility", or "skilled nursing facility" may not be defined more restrictively than as defined in the medicare program.

4. "Health care expenses" means expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers. ~~Such expenses~~ Expenses may not include:

   a. Home office and overhead costs;

   b. Advertising costs;

   c. Commissions and other acquisition costs;

   d. Taxes;

   e. Capital costs;

   f. Administrative costs; and

   g. Claims processing costs.

5. "Hospital" may be defined in relation to its status, facilities, and available services or to reflect its accreditation by the joint commission on accreditation of

hospitals, but not more restrictively than as defined in the medicare program.

6. "Medicare" must be defined in the policy and certificate. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended", or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof", or words of similar import.

7. "Medicare eligible expenses" means expenses of the kinds covered by medicare, to the extent recognized as reasonable and medically necessary by medicare.

8. "Physician" may not be defined more restrictively than as defined in the medicare program.

9. "Sickness" may not be defined to be more restrictive than the following: "Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force." The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability, or similar law.

History: Effective January 1, 1992; amended effective July 8, 1997.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1

45-06-01.1-04. Policy provisions.

1. Except for permitted preexisting condition clauses as described in subdivision a of subsection 1 of section 45-06-01.1-05 and subdivision a of subsection 1 of section 45-06-01.1-06, no policy or certificate may be advertised, solicited, or issued for delivery in this state as a medicare supplement policy if ~~such~~ the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of medicare.

2. No medicare supplement policy or certificate may use waivers to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

3. No medicare supplement policy or certificate in force in the state may contain benefits which duplicate benefits provided by medicare.

History: Effective January 1, 1992; amended effective July 8, 1997.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-05. Minimum benefit standards for policies or certificates issued for delivery prior to January 1, 1992. No policy or certificate may be advertised, solicited, or issued for delivery in this state as a medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards:

1. **General standards.** The following standards apply to medicare supplement policies and certificates and are in addition to all other requirements of this rule:

   a. A medicare supplement policy or certificate may not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

   b. A medicare supplement policy or certificate may not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

   c. A medicare supplement policy or certificate must provide that benefits designed to cover cost-sharing amounts under medicare will be changed automatically to coincide with any changes in the applicable medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

   d. A "noncancelable", "guaranteed renewable", or "noncancelable and guaranteed renewable" medicare supplement policy may not:

      (1) Provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or

      (2) Be canceled or nonrenewed by the issuer solely on the grounds of deterioration of health.

   e. (1) Except as authorized by the commissioner of this state, an issuer may neither cancel nor nonrenew a medicare supplement policy or certificate for any

reason other than nonpayment of premium or material misrepresentation.

(2) If a group medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in paragraph 4, the issuer must offer certificate holders an individual medicare supplement policy. The issuer must offer the certificate holder at least the following choices:

(a) An individual medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group medicare supplement policy; and

(b) An individual medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in subsection 2 of section 45-06-01.1-06.

(3) If membership in a group is terminated, the issuer must:

(a) Offer the certificate holder ~~such~~ the conversion opportunities ~~as are~~ described in paragraph 2; or

(b) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(4) If a group medicare supplement policy is replaced by another group medicare supplement policy purchased by the same policyholder, the ~~succeeding~~ issuer of the replacement policy must offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy may not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

f. Termination of a medicare supplement policy or certificate must be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits.

2. **Minimum benefit standards.**

a. Coverage of part A medicare eligible expenses for hospitalization to the extent not covered by medicare from the sixty-first day through the ninetieth day in any medicare benefit period.

b. Coverage for either all or none of the medicare part A inpatient hospital deductible amount.

c. Coverage of part A medicare eligible expenses incurred as daily hospital charges during use of medicare's lifetime hospital inpatient reserve days.

d. Upon exhaustion of all medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent of all medicare part A eligible expenses for hospitalization not covered by medicare subject to a lifetime maximum benefit of an additional three hundred sixty-five days.

e. Coverage under medicare part A for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under part B.

f. Coverage for the coinsurance amount of medicare eligible expenses under part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the medicare part B deductible (one hundred dollars).

g. Effective January 1, 1990, coverage under medicare part B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under part A, subject to the medicare deductible amount.

History: Effective January 1, 1992; amended effective July 1, 1994; April 1, 1996; July 8, 1997.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-06. Benefit standards for policies or certificates issued or delivered on or after January 1, 1992. The following standards are applicable to all medicare supplement policies or certificates delivered or issued for delivery in this state on or after January 1, 1992. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a medicare supplement policy or certificate unless it complies with these benefit standards:

1. **General standards.** The following standards apply to medicare supplement policies and certificates and are in addition to all other requirements of this rule:

   a. A medicare supplement policy or certificate may not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

   b. A medicare supplement policy or certificate may not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

   c. A medicare supplement policy or certificate must provide that benefits designed to cover cost-sharing amounts under medicare will be changed automatically to coincide with any changes in the applicable medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

   d. No medicare supplement policy or certificate may provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

   e. Each medicare supplement policy must be guaranteed renewable and:

      (1) The issuer may not cancel or nonrenew the policy solely on the ground of health status of the individual.

      (2) The issurer may not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

      (3) If the medicare supplement policy is terminated by the group policyholder and is not replaced as provided under paragraph 5 of subdivision e of subsection 1 of section 45-06-01.1-06, the issuer must offer certificate holders an individual medicare supplement policy which (at the option of the certificate holder):

         (a) Provides for continuation of the benefits contained in the group policy; or

(b) Provides for ~~such~~ benefits as that otherwise ~~meets~~ meet the requirements of this subsection.

(4) If an individual is a certificate holder in a group medicare supplement policy and the individual terminates membership in the group, the issuer must:

(a) Offer the certificate holder the conversion opportunity described in paragraph 3 of subdivision e of subsection 1 of section 45-06-01.1-06; or

(b) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(5) If a group medicare supplement policy is replaced by another group medicare supplement policy purchased by the same policyholder, the ~~succeeding~~ issuer of the replacement policy must offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy may not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

f. Termination of a medicare supplement policy or certificate must be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.

g. (1) A medicare supplement policy or certificate must provide that benefits and premiums under the policy or certificate must be suspended at the request of the policyholder or certificate holder for the period (not to exceed twenty-four months) in which the policyholder or certificate holder has applied for and is determined to be entitled to medicaid under title XIX of the Social Security Act [42 U.S.C. 1396, et seq.], but only if the policyholder or certificate holder notifies the issuer of ~~such~~ the policy or certificate within ninety days after the date the individual becomes entitled to ~~such~~ assistance. Upon receipt of timely notice, the issuer shall return to the policyholder or certificate holder that portion of the premium attributable to the period of medicaid eligibility, subject to adjustment for paid claims.

(2) If ~~such~~ suspension occurs and if the policyholder or certificate holder loses entitlement to ~~such~~ medical assistance, ~~such~~ the policy or certificate shall be automatically reinstituted (effective as of the date of termination of ~~such~~ entitlement) as of the termination of ~~such~~ entitlement if the policyholder or certificate holder provides notice of loss of ~~such~~ entitlement within ninety days after the date of ~~such~~ loss and pays the premium attributable to the period, effective as of the date of termination of ~~such~~ entitlement.

(3) Reinstitution of ~~such~~ coverages:

(a) May not provide for any waiting period with respect to treatment of preexisting conditions;

(b) Must provide for coverage which is substantially equivalent to coverage in effect before the date of ~~such~~ suspension; and

(c) Must provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

2. **Standards for basic (core) benefits common to all benefit plans.** Every issuer must make available a policy or certificate including only the following basic core package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other medicare supplement insurance benefit plans in addition to the basic core package, but not in lieu thereof:

a. Coverage of part A medicare eligible expenses for hospitalization to the extent not covered by medicare from the sixty-first day through the ninetieth day in any medicare benefit period.

b. Coverage of part A medicare eligible expenses incurred for hospitalization to the extent not covered by medicare for each medicare lifetime inpatient reserve day used.

c. Upon exhaustion of the medicare hospital inpatient coverage including the lifetime reserve days, coverage of the medicare part A eligible expenses for hospitalization paid at the diagnostic related group day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five days.

d. Coverage under medicare parts A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

e. Coverage for the coinsurance amount of medicare eligible expenses under part B regardless of hospital confinement, subject to the medicare part B deductible.

3. **Standards for additional benefits.** The following additional benefits must be included in medicare supplement benefit plans "B" through "J" only as provided by section 45-06-01.1-07:

a. Medicare part A deductible: Coverage for all of the medicare Part A inpatient hospital deductible amount per benefit period.

b. Skilled nursing facility care: Coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredth day in a medicare benefit period for posthospital skilled nursing facility care eligible under medicare part A.

c. Medicare part B deductible: Coverage for all of the medicare part B deductible amount per calendar year regardless of hospital confinement.

d. Eighty percent of the medicare part B excess charges: Coverage for eighty percent of the difference between the actual medicare part B charge as billed, not to exceed any charge limitation established by the medicare program or state law, and the medicare-approved part B charge.

e. One hundred percent of the medicare part B excess charges: Coverage for all of the difference between the actual medicare part B charge as billed, not to exceed any charge limitation established by the medicare program or state law, and the medicare-approved part B charge.

f. Basic outpatient prescription drug benefit: Coverage for fifty percent of outpatient prescription drug charges, after a two hundred fifty dollar calendar year deductible, to a maximum of one thousand two hundred fifty dollars in benefits received by the insured per calendar year, to the extent not covered by medicare.

g. Extended outpatient prescription drug benefit: Coverage for fifty percent of outpatient prescription drug charges, after a two hundred fifty dollar calendar year deductible to a maximum of three thousand dollars in benefits received by the insured per calendar year, to the extent not covered by medicare.

h. Medically necessary emergency care in a foreign country: Coverage to the extent not covered by medicare for eighty percent of the billed charges for medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign county, which care would have been covered by medicare if provided in the United States and which care began during the first sixty consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars, and a lifetime maximum benefit of fifty thousand dollars. For purposes of this benefit, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.

i. Preventive medical care benefit: Coverage for the following preventive health services:

(1) An annual clinical preventive medical history and physical examination that may include tests and services from subparagraph 2 and patient education to address preventive health care measures.

(2) Any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(a) Fecal occult blood test or digital rectal examination, or both.

(b) Mammogram.

(c) Dipstick urinalysis for hematuria, bacteriuria, and proteinauria.

(d) Pure tone, air only, hearing screening test, administered or ordered by a physician.

(e) Serum cholesterol screening every five years.

(f) Thyroid function test.

(g) Diabetes screening.

(3) Influenza vaccine administered at any appropriate time during the year and tetanus and diphtheria booster every ten years.

(4) Any other tests or preventive measures determined appropriate by the attending physician.

Reimbursement must be for the actual charges up to one hundred percent of the medicare-approved amount for each service, as if medicare were to cover the service as

identified in American medical association current procedural terminology codes, to a maximum of one hundred twenty dollars annually under this benefit. This benefit may not include payment for any procedure covered by medicare.

j. At-home recovery benefit: Coverage for services to provide short-term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery.

(1) For purposes of this benefit, the following definitions apply:

(a) "Activities of daily living" includes, but is not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

(b) "Care provider" means a duly qualified or licensed home health aide or homemaker, personal care aide, or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

(c) "Home" means any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by medicare. A hospital or skilled nursing facility may not be considered the insured's place of residence.

(d) "At-home recovery visit" means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive four hours in a twenty-four-hour period of services provided by a care provider is one visit.

(2) Coverage requirements and limitations.

(a) At-home recovery services provided must be primarily services which assist in activities of daily living.

(b) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by medicare.

(c) Coverage is limited to:

(i) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits may not exceed the number of medicare-approved home health care visits under a medicare-approved home care plan of treatment.

(ii) The actual charges for each visit up to a maximum reimbursement of forty dollars per visit.

(iii) One thousand six hundred dollars per calendar year.

(iv) Seven visits in any one week.

(v) Care furnished on a visiting basis in the insured's home.

(vi) Services provided by a care provider as defined in this section.

(vii) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded.

(viii) At-home recovery visits received during the period the insured is receiving medicare-approved home care services or no more than eight weeks after the service date of the last medicare approved home health care visit.

(3) Coverage is excluded for:

(a) Home care visits paid for by medicare or other government programs; and

(b) Care provided by family members, unpaid volunteers, or providers who are not care providers.

k. New or innovative benefits. An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. ~~Such~~ The new or innovative benefits may include benefits that are appropriate to medicare supplement insurance, new or

innovative, not otherwise available, cost effective, and offered in a manner which is consistent with the goal of simplification of medicare supplement policies. New or innovative benefits should offer uniquely different or significantly expanded coverages.

History: Effective January 1, 1992; amended effective April 1, 1996; July 8, 1997.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-08. Medicare select policies and certificates.

1. a. This section applies to medicare select policies and certificates, as defined in this section.

   b. No policy or certificate may be advertised as a medicare select policy or certificate unless it meets the requirements of this section.

2. For the purposes of this section:

   a. "Complaint" means any dissatisfaction expressed by an individual concerning a medicare select issuer or its network providers.

   b. "Grievance" means dissatisfaction expressed in writing by an individual insured under a medicare select policy or certificate with the administration, claims practices, or provision of services concerning a medicare select issuer or its network providers.

   c. "Medicare select issuer" means an issuer offering, or seeking to offer, a medicare select policy or certificate.

   d. "Medicare select policy" or "medicare select certificate" mean respectively a medicare supplement policy or certificate that contains restricted network provisions.

   e. "Network provider" means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a medicare select policy.

   f. "Restricted network provision" means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

   g. "Service area" means the geographic area approved by the commissioner within which an issuer is authorized to offer a medicare select policy.

3. The commissioner may authorize an issuer to offer a medicare select policy or certificate, pursuant to this section and section 4358 of the Omnibus Budget Reconciliation Act of 1990 [Pub. L. 101-508; 104 Stat. 1388; 42 U.S.C. 1395ss(t)(1)] if the commissioner finds that the issuer has satisfied all of the requirements of this regulation.

4. A medicare select issuer may not issue a medicare select policy or certificate in this state until its plan of operation has been approved by the commissioner.

5. A medicare select issuer must file a proposed plan of operation with the commissioner in a format prescribed by the commissioner. The plan of operation must contain at least the following information:

   a. Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

      (1) ~~Such--services~~ Services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation, and after-hour care. The hours of operation and availability of after-hour care must reflect usual practice in the local area. Geographic availability must reflect the usual traveltimes within the community.

      (2) The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:

         (a) To deliver adequately all services that are subject to a restricted network provision; or

         (b) To make appropriate referrals.

      (3) There are written agreements with network providers describing specific responsibilities.

      (4) Emergency care is available twenty-four hours per day and seven days per week.

      (5) In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting ~~such~~ the providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a medicare select policy or certificate. This paragraph does not apply to supplemental charges or

coinsurance amounts as stated in the medicare select policy or certificate.

b. A statement or map providing a clear description of the service area.

c. A description of the grievance procedure to be utilized.

d. A description of the quality assurance program, including:

(1) The formal organizational structure;

(2) The written criteria for selection, retention, and removal of network providers; and

(3) The procedures for evaluating quality of care provided by network providers and the process to initiate corrective action when warranted.

e. A list and description, by specialty, of the network providers.

f. Copies of the written information proposed to be used by the issuer to comply with subsection 9.

g. Any other information requested by the commissioner.

6. a. A medicare select issuer must file any proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner prior to implementing such changes. Such changes must be considered approved by the commissioner after thirty days unless specifically disapproved.

b. An updated list of network providers must be filed with the commissioner at least quarterly.

7. A medicare select policy or certificate may not restrict payment for covered services provided by non-network providers if:

a. The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury, or a condition; and

b. It is not reasonable to obtain such services through a network provider.

8. A medicare select policy or certificate must provide payment for full coverage under the policy for covered services that are not available through network providers.

9. A medicare select issuer must make full and fair disclosure in writing of the provisions, restrictions, and limitations of the medicare select policy or certificate to each applicant. This disclosure must include at least the following:

   a. An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the medicare select policy or certificate with:

      (1) Other medicare supplement policies or certificates offered by the issuer; and

      (2) Other medicare select policies or certificates.

   b. A description (including address, telephone number, and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals, and other providers.

   c. A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized.

   d. A description of coverage for emergency and urgently needed care and other out-of-service area coverage.

   e. A description of limitations on referrals to restricted network providers and to other providers.

   f. A description of the policyholder's rights to purchase any other medicare supplement policy or certificate otherwise offered by the issuer.

   g. A description of the medicare select issuer's quality assurance program and grievance procedure.

10. Prior to the sale of a medicare select policy or certificate, a medicare select issuer must obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to subsection 9 and that the applicant understands the restrictions of the medicare select policy or certificate.

11. A medicare select issuer must have and use procedures for hearing complaints and resolving written grievances from the subscribers. Such procedures must be aimed at mutual agreement for settlement and may include arbitration procedures.

    a. The grievance procedure must be described in the policy and certificates and in the outline of coverage.

b. At the time the policy or certificate is issued, the issuer must provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

c. Grievances must be considered in a timely manner and shall be transmitted to appropriate decisionmakers who have authority to fully investigate the issue and take corrective action.

d. If a grievance is found to be valid, corrective action must be taken promptly.

e. All concerned parties must be notified about the results of a grievance.

f. The issuer must report no later than each March thirty-first to the commissioner regarding its grievance procedure. The report must be in a format prescribed by the commissioner and must contain the number of grievances filed in the past year and a summary of the subject, nature, and resolution of such grievances.

12. At the time of initial purchase, a medicare select issuer must make available to each applicant for a medicare select policy or certificate the opportunity to purchase any medicare supplement policy or certificate otherwise offered by the issuer.

13. a. At the request of an individual insured under a medicare select policy or certificate, a medicare select issuer must make available to the individual insured the opportunity to purchase a medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer must make ~~such~~ the policies or certificates available without requiring evidence of insurability after the medicare ~~supplement~~ select policy or certificate has been in force for six months.

b. For the purposes of this subsection, a medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the medicare select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the medicare part A deductible, coverage for prescription drugs, coverage for at-home recovery services, or coverage for medicare part B excess charges.

14. Medicare select policies and certificates must provide for continuation of coverage in the event the secretary of health and human services determines that medicare select policies

and certificates issued pursuant to this section should be discontinued due to either the failure of the medicare select program to be reauthorized under law or its substantial amendment.

a. Each medicare select issuer must make available to each individual insured under a medicare select policy or certificate the opportunity to purchase any medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer must make such policies and certificates available without requiring evidence of insurability.

b. For the purposes of this subsection, a medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the medicare select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the medicare part A deductible, coverage for prescription drugs, coverage for at-home recovery services, or coverage for part B excess charges.

15. A medicare select issuer must comply with reasonable requests for data made by state or federal agencies, including the United States department of health and human services, for the purpose of evaluating the medicare select program.

History: Effective January 1, 1992; amended effective July 8, 1997.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-09. Open enrollment.

1. ~~No~~ Any issuer may not deny or condition the issuance or effectiveness of any medicare supplement policy or certificate available for sale in this state, ~~nor~~ or discriminate in the pricing of such a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant ~~where~~ in the case of an application for ~~such~~ a policy or certificate that is submitted prior to or during the six-month period beginning with the first day of the first month in which an individual ~~(who~~ is both sixty-five years of age or older~~)-first~~ and is enrolled for benefits under medicare part B. Each medicare supplement policy and certificate currently available from an insurer must be made available to all applicants who qualify under this subsection without regard to age.

2. ~~Subsection~~ Except as provided in subsection 1 of section 45-06-01.1-20, may not be construed as preventing the

exclusion of benefits under a policy, during the first six months, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six months before ~~it~~ the coverage became effective.

History: Effective January 1, 1992; amended effective July 8, 1997.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-11. Loss ratio standards and refund or credit of premium.

1. **Loss ratio standards:**

   a. (1) A medicare supplement policy form or certificate form may not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form:

      ~~(1)~~ (a) At least seventy-five percent of the aggregate amount of premiums earned in the case of group policies; or

      ~~(2)~~ (b) At least sixty-five percent of the aggregate amount of premiums earned in the case of individual policies~~,-calculated~~;

      (2) Calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for such period and in accordance with accepted actuarial principles and practices.

   b. All filings of rates and rating schedules must demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions must also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

   c. For purposes of applying subdivision a of subsection 1 of this section and subdivision c of subsection 3 of section 45-06-01.1-12 only, policies issued as a result of

solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) are deemed to be group policies.

d. For policies issued prior to January 1, 1992, expected claims in relation to premiums must meet:

(1) The originally filed anticipated loss ratios for all individual policies, including all group policies subject to an individual loss ratio standard when issued, combined and all other group policies combined with the actual experience since inception;

(2) The appropriate loss ratio requirements from subparagraphs a and b of paragraph 1 of subdivision a when combined with actual experience beginning with July 1, 1997, to date; and

(3) The appropriate loss ratio requirement from subparagraphs a and b of paragraph 1 of subdivision a over the entire future period for which the rates are computed to provide coverage.

2. **Refund or credit calculation:**

a. An issuer must collect and file with the commissioner by May thirty-first of each year the data contained in the applicable reporting form contained in appendix A for each type in a standard medicare supplement benefit plan.

b. If on the basis of the experience as reported the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation must be done on a statewide basis for each type in a standard medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year must be excluded.

c. For the purposes of this section, policies or certificates issued prior to January 1, 1992, the issuer shall make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after July 1, 1997. The first report is due by May 31, 1998.

d. A refund or credit may be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. ~~Such~~ The refund must include interest from the end of the calendar year to the date of the refund or credit

at a rate specified by the secretary of health and human services, but in no event may it be less than the average rate of interest for thirteen-week treasury notes. A refund or credit against premiums due must be made by September thirtieth following the experience year upon which the refund or credit is based.

3. **Annual filing of premium rates.** An issuer of medicare supplement policies and certificates issued before or after the effective date of this chapter must file annually its rates, rating schedule, and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner. The supporting documentation must also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. ~~Such~~ The demonstration must exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage must be demonstrated for policies or certificates in force less than three years.

   As soon as practicable, but prior to the effective date of enhancements in medicare benefits, every issuer of medicare supplement policies or certificates in this state must file with the commissioner, in accordance with the applicable filing procedures of this state:

   a. (1) Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. ~~Such~~ The supporting documents as necessary to justify the adjustment must accompany the filing.

      (2) An issuer must make ~~such~~ premium adjustments ~~as are~~ necessary to produce an expected loss ratio under ~~such~~ the policy or certificate ~~as will~~ to conform ~~with~~ to minimum loss ratio standards for medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for ~~such~~ the medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein may be made with respect to a policy at any time other than upon its renewal date or anniversary date.

      (3) If an issuer fails to make premium adjustments acceptable to the commissioner, the commissioner may

order premium adjustments, refunds, or premium credits deemed necessary to achieve the loss ratio required by this section.

b. Any appropriate riders, endorsements, or policy forms needed to accomplish the medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with medicare. ~~Such~~ The riders, endorsements, or policy forms must provide a clear description of the medicare supplement benefits provided by the policy or certificate.

4. **Public hearings.** The commissioner may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of this chapter if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for such reporting period. Public notice of ~~such~~ the hearing may be furnished in a manner deemed appropriate by the commissioner.

History: Effective January 1, 1992; amended effective July 8, 1997.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-04

45-06-01.1-14. Required disclosure provisions.

1. **General rules.**

a. Medicare supplement policies and certificates must include a renewal or continuation provision. The language or specifications of ~~such~~ the provision must be consistent with the type of contract issued. Such provision must be appropriately captioned and must appear on the first page of the policy, and must include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

b. Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of medicare benefits, all riders or endorsements added to a medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy must require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term

must be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for medicare supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, ~~such~~ the premium charge must be set forth in the policy.

c. Medicare supplement policies or certificates may not provide for the payment of benefits based on standards described as "usual and customary", "reasonable and customary", or words of similar import.

d. If a medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations must appear as a separate paragraph of the policy and be labeled as "preexisting condition limitations".

e. Medicare supplement policies and certificates must have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificate holder has the right to return the policy or certificate within thirty days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

f. (1) Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for medicare must provide to ~~such~~ those applicants a guide to health insurance for people with medicare in the form developed jointly by the national association of insurance commissioners and the health care financing administration and in a type size no smaller than twelve-point type. Delivery of the ~~buyer's~~ guide must be made whether or not such policies or certificates are advertised, solicited, or issued as medicare supplement policies or certificates as defined in this regulation. Except in the case of direct response issuers, delivery of the ~~buyer's~~ guide must be made to the applicant at the time of application and acknowledgment of receipt of the ~~buyer's~~ guide must be obtained by the insurer. Direct response issuers must deliver the ~~buyer's~~ guide to the applicant upon request but not later than at the time the policy is delivered.

(2) For the purposes of this section, "form" means the language, format, type size, type proportional spacing, bold character, and line spacing.

2. **Notice requirements.**

a. As soon as practicable, but no later than thirty days prior to the annual effective date of any medicare benefit changes, an issuer must notify its policyholders and certificate holders of modifications it has made to medicare supplement insurance policies or certificates in a format acceptable to the commissioner. ~~Such~~ The notice must:

(1) Include a description of revisions to the medicare program and a description of each modification made to the coverage provided under the medicare supplement policy or certificate; and

(2) Inform each policyholder or certificate holder as to when any premium adjustment is to be made due to changes in medicare.

b. The notice of benefit modifications and any premium adjustments must be in outline form and in clear and simple terms so as to facilitate comprehension.

c. Such notices may not contain or be accompanied by any solicitation.

3. **Outline of coverage requirements for medicare supplement policies.**

a. Issuers must provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, must obtain an acknowledgment of receipt of ~~such~~ the outline from the applicant; and

b. If an outline of coverage is provided at the time of application and the medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany such policy or certificate when it is delivered and contain the following statement, in no less than twelve-point type, immediately above the company name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

c. The outline of coverage provided to applicants pursuant to this section must consist of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by

the issuer. The outline of coverage must be in the language and format prescribed below in no less than twelve-point type. All plans "A" through "J" must be shown on the cover page, and the plans that are offered by the issuer must be prominently identified. Premium information for plans that are offered must be shown on the cover page or immediately following the cover page and must be prominently displayed. The premium and mode must be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant must be illustrated.

d. The following items must be included in the outline of coverage in the order prescribed below:

CHART - Outline of Medicare Supplement Coverage - Cover Page
(NO CHANGE)

PREMIUM INFORMATION

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this state. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs.

[for agents:]
Neither [insert company's name] nor its agents are connected with medicare.

[for direct response:]
[insert company's name] is not connected with medicare.

This outline of coverage does not give all the details of medicare coverage. Contact your local Social Security Office or consult "The medicare Handbook" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page, a chart showing the services, medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to subsection 4 of section 45-06-01.1-07 of this chapter.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the commissioner.]

Plan H - Medicare (Part B) - Medical Services - Per Calendar Year is amended. Under the column entitled "Plan Pays", the Part B Excess Charges (Above Medicare Approved Amounts) under the column entitled "Services" is changed from 80% to $0. Replacement page is as follows:

PLAN H

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

(continued)

4. a. **Notice regarding policies or certificates** that **are not medicare supplement policies.**

   a. Any accident and sickness insurance policy certificate, other than a medicare supplement policy; ~~or~~ a policy issued pursuant to a contract under section 1876 ~~or section 1833~~ of the Social Security Act [42 U.S.C. 1395 et seq.]~~;~~; disability income policy; or other policy identified in subsection 2 of section 45-06-01.1-01, issued for delivery in this state to persons eligible for medicare, must notify insureds under the policy that the policy is not a medicare supplement policy or certificate. The notice must either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. ~~Such~~ The notice must be in no less than twelve-point type and must contain the following language:

   "THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People With Medicare available from the company."

   b. Applications provided to persons eligible for medicare for the health insurance policies for certificates described in subdivision a must disclose, using the applicable statement in appendix C, the extent to which the policy duplicates medicare. The disclosure statement must be provided as a part of, or together with, the application for the policy or certificate.

History: Effective January 1, 1992; amended effective August 1, 1992; July 1, 1994; April 1, 1996; July 8, 1997.
General Authority: NDCC 26.1-36.1-03, 26.1-36.1-05
Law Implemented: NDCC 26.1-36.1-05

45-06-01.1-15. Requirements for application forms and replacement coverage.

1. Application forms must include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another medicare supplement or other health insurance policy or certificate in force or whether a medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing such questions and statements may be used.

[Statements]

1. You do not need more than one Medicare supplement policy.

2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

4. The benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstituted if requested within 90 days of losing Medicaid eligibility.

5. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning ~~Medicaid~~ medical assistance through the state Medicaid program, including benefits as a qualified medicare beneficiary (QMB) and a special low-income medicare beneficiary (SLMB).

[Questions]

To the best of your knowledge,

1. Do you have another Medicare supplement policy or certificate in force ~~(including health care service contract, health maintenance organization contract)~~?

   a. If so, with which company?

   b. If so, do you intend to replace your current Medicare supplement policy with this policy (certificate)?

2. Do you have any other health insurance coverage that provides benefits similar to this Medicare supplement policy?

   a. If so, with which company?

   b. What kind of policy?

3. Are you covered for medical assistance through the state Medicaid program:?

a. As a specified low-income medicare beneficiary (SLMB)?

b. As a qualified medicare beneficiary (QMB)?

c. For other Medicaid medical benefits?

2. Agents shall list any other health insurance policies they have sold to the applicant.

   a. List policies sold which are still in force.

   b. List policies sold in the past five years which are no longer in force.

3. In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, must be returned to the applicant by the insurer upon delivery of the policy.

4. Upon determining that a sale will involve replacement of medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, must furnish the applicant, prior to issuance or delivery of the medicare supplement policy or certificate, a notice regarding replacement of medicare supplement coverage. One copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, must be provided to the applicant and an additional signed copy must be retained by the issuer. A direct response issuer must deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of medicare supplement coverage.

5. The notice required by subsection 4 for an issuer must be provided in substantially the following form in no less than twelve point type:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement

coverage is a wise decision, you should terminate your present Medicare supplement coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. ~~The replacement of insurance involved in this transaction will not duplicate~~ To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement coverage because you intend to terminate your existing Medicare supplement coverage. The replacement policy is being purchased for the following ~~reason(s)~~ reason (check one):

____ Additional benefits.
____ No change in benefits, but lower premiums.
____ Fewer benefits and lower premiums.
____ Other. (please specify)

_____
_____
_____

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____
(Signature of Agent, Broker or Other Representative)*

[Typed Name and Address of Issuer, Agent or Broker]

_____
(Applicant's Signature)

_____
(Date)

*Signature not required for direct response sales.

6. Paragraphs 1 and 2 of the replacement notice (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

History: Effective January 1, 1992; amended effective July 1, 1994; April 1, 1996; July 8, 1997.
General Authority: NDCC 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02, 26.1-36.1-05

STAFF COMMENT

Appendix A - Medicare Supplement Refund Calculation Form
The following new language has been added to footnote 2:
- Use "P: for prestandardized plans.
The form has also been reformated.
Replace entire Appendix A with the following four pages:

Appendix A

MEDICARE SUPPLEMENT REFUND CALCULATION FORM FOR CALENDAR YEAR_____

TYPE[1] _____ SMSBP[2] _____
For the State of _____ Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____ Person Completing Exhibit _____
Title _____ Telephone Number _____

Line		(a) Earned Premium[3]	(b) Incurred Claims[4]
1.	Current Year's Experience		
	a. Total (all policy years)		
	b. Current year's issues[5]		
	c. Net (for reporting purposes = 1a–1b		
2.	Past Years' Experience (all policy years)		
3.	Total Experience (Net Current Year + Past Year)		

4.	Refunds Last Year (Excluding Interest)	
5.	Previous Since Inception (Excluding Interest)	
6.	Refunds Since Inception (Excluding Interest)	
7.	Benchmark Ratio Since Inception (*see worksheet for Ratio 1*)	
8.	Experienced Ratio Since Inception (*Ratio 2*) Total Actual Incurred Claims (line 3, col. b) Total Earned Prem. (line 3, col. a)–Refunds Since Inception (line 6)	
9.	Life Years Exposed Since Inception If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.	
10.	Tolerance Permitted (obtained from credibility table)	

Medicare Supplement Credibility Table

Life Years Exposed Since Inception	Tolerance
10,000 +	0.0%
5,000 -9,999	5.0%
2,500 -4,999	7.5%
1,000 -2,499	10.0%
500 - 999	15.0%
If less than 500, no credibility.	

[1] Individual, Group, Individual Medicare Select, or Group Medicare Select Only.

[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.

[3] Includes Modal Loadings and Fees Charged

[4] Excludes Active Life Reserves

[5] This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios"

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR_____

TYPE[1] _____ SMSBP[2] _____
For the State of _____ Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____ Person Completing Exhibit _____
Title _____ Telephone Number _____

11.	Adjustment to Incurred Claims for Credibility Ratio 3 = Ratio 2 + Tolerance	

If Ratio 3 is more than Benchmark Ratio (Ratio 1), a refund or credit to premium is not required.
If Ratio 3 is less than the Benchmark Ratio, then proceed.

12.	Adjusted Incurred Claims [Total Earned Premiums (line 3, col. a)–Refunds Since Inception (line 6)] x Ratio 3 (line 11)	
13.	Refund = Total Earned Premiums (line 3, col. a)–Refunds Since Inception (line 6) –[Adjusted Incurred Claims (line 12)/Benchmark Ratio (Ratio 1)]	

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund or credit against premiums to be used must be attached to this form.

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____
Signature

_____
Name - Please Type

_____
Title - Please Type

_____
Date

REPORTING FORM FOR THE CALCULATION OF BENCHMARK
RATIO SINCE INCEPTION FOR INDIVIDUAL POLICIES
FOR CALENDAR YEAR_____

TYPE[1] _____ SMSBP[2]_____
For the State of _____ Company Name _____
NAIC Group Code_____ NAIC Company Code _____
Address_____ Person Completing Exhibit _____
Title _____ Telephone Number _____

(a)[3]	(b)[4]	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)[5]
Year	Earned Premium	Factor	(b)x(c)	Cumulative Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumulative Loss Ratio	(h)x(i)	Policy Year Loss Ratio
1		2.770		0.442		0.000		0.000		0.40
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15		4.175		0.493		8.684		0.725		0.77
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: (l + n)/(k + m): _____

[1] Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans
[3] Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)
[4] For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.
[5] These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

REPORTING FORM FOR THE CALCULATION OF BENCHMARK
RATIO SINCE INCEPTION FOR GROUP POLICIES
FOR CALENDAR YEAR_____

TYPE[1] _____ SMSBP[2] _____
For the State of _____ Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____ Person Completing Exhibit _____
Title _____ Telephone Number _____

(a)[3]	(b)[4]	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)[5]
Year	Earned Premium	Factor	(b)x(c)	Cumulative Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumulative Loss Ratio	(h)x(i)	Policy Year Loss Ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.80
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15		4.175		0.567		8.684		0.838		0.89
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: (l + n)/(k + m): _____

[1]Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
[2]"SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans
[3] Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)
[4] For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.
[5]These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

Appendix B - Replace all pages with 1 page as follows:

APPENDIX B

FORM FOR REPORTING
MEDICARE SUPPLEMENT POLICIES

Company Name: _____

Address: _____

_____

Phone Number: _____

Due March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and Certificate #	Date of Issuance

_____
Signature

_____
Name and Title (please type)

_____
Date

[For policies that provide benefits for expenses incurred for an accidental injury only]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

TITLE 54

Nursing, Board of

DECEMBER 1997

CHAPTER 54-05-03.1

54-05-03.1-04. Initial requirements for advanced practice registered nurse licensure. Applicants for advanced practice registered nurse licensure must:

1. Possess a current license to practice as a registered nurse in North Dakota;

2. Submit evidence of completion of an advanced nursing education program ~~prior to July 31, 1995~~ through December 31, 2000, or submit evidence of completion of the requirements for a graduate education program with a nursing focus ~~after August 1, 1995~~ beginning January 1, 2001. The exception is the women's health care nurse practitioner who must submit evidence of completion of an advanced nursing education program through December 31, 2006, or submit evidence of completion of the requirements for a graduate education program with a nursing focus beginning January 1, 2007;

3. Submit evidence of current certification by a national nursing certifying body in the specific area of nursing practice;

4. Submit a completed notarized application and pay the fee of one hundred dollars; and

5. Submit a scope of practice statement according to established board guidelines for review and approval by the board of nursing.

Applicants who have been issued a registered nurse temporary permit and meet all of the qualifications for advanced licensure may be issued a

temporary advanced practice registered nurse license with the same date of expiration. The advanced practice registered nurse license will be issued to coincide with the renewal date of the initial registered nurse license.

History: Effective March 1, 1992; amended effective November 1, 1996; December 1, 1997.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-09(4)(5)

54-05-03.1-09. Requirements for prescriptive authority. Applicants for prescriptive authority shall:

1. Be currently licensed as an advanced practice registered nurse in North Dakota.

2. Have--~~completed~~ Submit evidence of completion of an advanced nursing education program ~~prior--to--July-31,--1995~~ through December 31, 2000, or submit evidence of completion of the requirements for a graduate education program with a nursing focus ~~after--August-1,--1995~~ beginning January 1, 2001. The exception is the women's health care nurse practitioner who must submit evidence of completion of an advanced nursing education program through December 31, 2006, or submit evidence of completion of the requirements for a graduate education program with a nursing focus beginning January 1, 2007.

3. Submit a complete, notarized prescriptive authority application and pay the fee of fifty dollars.

4. Provide evidence of completion of thirty contact hours of education in pharmacotherapy related to the applicant's scope of advanced practice that:

   a. Include pharmacokinetic principles and their clinical application and the use of pharmacological agents in the prevention of illness, restoration, and maintenance of health.

   b. Have been obtained within a three-year period of time immediately prior to the date of application for prescriptive authority.

   c. Have been obtained from one or more of the following methods:

      (1) Two academic semester hour credits in pharmacotherapy related to scope of practice is the equivalent of thirty contact hours;

(2) Evidence of attendance at an approved pharmacotherapy seminar, lecture, workshop, class, or course either in person or via a telecommunication network may be submitted for part or all of the thirty contact hours;

(3) Evidence of participation in an approved pharmacotherapy correspondence or home study continuing education course may be submitted for no more than one-half of the thirty contact hours;

(4) Evidence of publication of one article related to pharmacotherapy in a refereed journal, one book chapter, or research project published in the license renewal timeframe may be submitted for a case-by-case review. Credit may be submitted for no more than one-sixth of the thirty contact hours;

(5) Evidence of participation as a presenter or lecturer for content related to pharmacotherapy is allowable, but credits may not total more than one-sixth of the requirement. A presentation or lecture of fifty minutes or more may not be used more than once in the three years. The presentation or lecture must be approved for contact hours or be offered as part of an academic course; and

(6) Other methods that may be approved by the board.

5. Include in the scope of practice statement required under subsection 5 of section 54-05-03.1-04 the nature and extent of the collaboration for prescriptive practices with a physician who is lawfully practicing medicine in North Dakota. The statement must address all of the following areas:

   a. Broad classifications of drugs or devices to be commonly prescribed by the advanced practice registered nurse;

   b. Methods and frequency of the collaboration for prescriptive practices, which must occur as client needs dictate, but are no less than once every two months;

   c. Methods of documentation of the collaboration process regarding prescriptive practices; and

   d. Alternative arrangements for collaboration regarding prescriptive practices in the temporary or extended absence of the physician.

6. Submit an affidavit from the licensed physician who will be participating in the collaborative prescriptive agreement acknowledging the manner of review and approval of the planned prescriptive practices. Information in the affidavit must

also indicate that the advanced practice registered nurse's scope of prescriptive practice is appropriately related to the collaborating physician's medical specialty or practice.

History: Effective March 1, 1992; amended effective November 1, 1996; December 1, 1997.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-02(7), 43-12.1-09(4)(5)

TITLE 56

Optometry, Board of

NOVEMBER 1997

CHAPTER 56-02-02

56-02-02-01. Postgraduate educational requirements. As a condition of the annual renewal of the license to practice optometry, every registered optometrist shall have attended during the three-year period preceding the date of renewal thirty-six classroom hours of optometric educational programs required by North Dakota Century Code section 43-13-20, hereinafter called educational requirements. Effective January 1, 2001, the educational requirements for the three-year period immediately preceding January 1, 2001, and for each reporting period thereafter, shall be fifty classroom hours.

History: Amended effective December 1, 1987; April 1, 1990; November 1, 1997.
General Authority: NDCC 43-13-13
Law Implemented: NDCC 43-13-20

56-02-05-08. Prescribing controlled substances. The secretary of the board shall certify to the federal drug enforcement agency each licensed optometrist authorized by the board to prescribe controlled substances. When used in this chapter, the term "controlled substances" means only those controlled pharmaceutical agents specifically authorized by North Dakota Century Code chapter 43-13 to be prescribed by optometrists.

1. Optometrists desiring to prescribe controlled substances must obtain and have a current drug enforcement agency registration number for schedule 3 as required for mid-level practitioners prior to prescribing controlled substances.

2. Optometrists desiring to prescribe controlled substances must comply with all federal, state, and local laws and regulations governing controlled substances, including the definition of controlled substances as found in North Dakota Century Code chapter 43-13. Violation of any such controlled substance laws or regulations may be grounds for criminal or civil prosecution under applicable law as well as disciplinary action by the board.

3. Optometrists are prohibited from possessing or dispensing any controlled substance as part of their practice. An optometrist may possess a controlled substance only when being treated for a legitimate medical condition and when such substance is administrated or prescribed by a person licensed and authorized to do so.

4. Optometrists who are authorized by the board to prescribe controlled substances and registered with the drug enforcement agency may only issue a prescription for a controlled substance listed in schedule 3 while acting in the normal course of the accepted standard of practice. The issuance of each such prescription must be for a legitimate medical purpose.

5. Optometrists who are authorized by the board to prescribe controlled substances and registered with the drug enforcement agency are prohibited from prescribing controlled substances for themselves.

6. Optometrists who are authorized by the board to prescribe controlled substances and registered with the drug enforcement agency are prohibited from prescribing controlled substances to persons known or suspected to be addicted to controlled substances.

7. The refill section of a prescription order issued by an authorized optometrist for a controlled substance must have the word "NO" written in it. The numeral "0" in this section or leaving the section blank is prohibited.

8. All controlled substance prescription orders issued by an authorized optometrist must have the number of dosage units (tablets) written out in the English language and, in addition, Arabic numbers must be recorded (e.g., "three" and in addition "3").

9. The controlled substance prescription order must be signed only by the issuing licensed optometrist authorized by the board to prescribe controlled substances and registered with the drug enforcement agency.

10. All prescription orders for controlled substances issued by an optometrist must be dated on and signed on the day when issued and must contain the full name and address of the patient, drug name, strength, dosage form, quantity prescribed, and directions for use and the name, address, and drug enforcement agency registration number of the licensed optometrist.

11. The licensed optometrist must maintain a separate written log of each controlled substance prescription issued. The log must be made available to the board upon request and must contain the patient's name, address, and date of prescription; the drug name, strength, and dosage form; and the quantity of controlled substances prescribed. The log must be made available to the drug enforcement agency or other law enforcement agencies as required by law.

History: Effective November 1, 1997.
General Authority: NDCC 43-13-13
Law Implemented: NDCC 43-13-01, 43-13-22

56-02-05-09. Certification to treat glaucoma. No optometrist may treat glaucoma until certified to do so as a therapeutically certified optometrist by the North Dakota state board of optometry.

History: Effective November 1, 1997.
General Authority: NDCC 43-13-13
Law Implemented: NDCC 43-13-01, 43-13-13.3

56-02-05-10. Glaucoma treatment certification requirements. Before being certified to treat glaucoma an optometrist must have:

1. Received a passing score on the clinical science part (part II) of the comprehensive examination given by the national board of examiners in optometry;

2. Received a passing score dated after January 1, 1992, on the treatment and management of ocular disease special examination given by the national board of examiners in optometry; or

3. Received a passing score in a course of study approved by the board equivalent to either the treatment and management of ocular disease or part II.

History: Effective November 1, 1997.
General Authority: NDCC 43-13-13
Law Implemented: NDCC 43-13-01, 43-13-13.3

56-02-05-11. Glaucoma treatment consultation. After initiating treatment for primary open angle glaucoma treatment, the therapeutically certified optometrist shall consult with a licensed ophthalmologist within seventy-two hours. The name of the ophthalmologist consulted and the treatment plan must be immediately entered in the patient's record.

History: Effective November 1, 1997.
General Authority: NDCC 43-13-13
Law Implemented: NDCC 43-13-01, 43-13-13.3

TITLE 63

Podiatric Medicine, Board of

JANUARY 1998

CHAPTER 63-01-05

63-01-05-01. Definitions. For purposes of this title, unless the context or subject matter otherwise requires:

1. "Board" means the North Dakota board of podiatric medicine.

2. "Clinical residency" means a formal, structured postdoctoral training program sponsored by and conducted in an accredited institution such as a hospital or ambulatory health care facility or conducted by a college of podiatric medicine accredited by the council on podiatric medical education or the American podiatric medical association. The residency must:

   a. Provide the podiatric medical graduate with a well-rounded exposure in preparation for management of podiatric conditions and diseases as they are related to systemic diseases;

   b. Develop the podiatric medical graduate in the art of preventing and controlling podiatric conditions and diseases and in the promotion of foot health principally through mechanical and rehabilitative methods;

   c. Provide the podiatric medical graduate with clinical experience necessary to refine competency in the podiatric medical and surgical care of the foot as defined by the statutory scope of practice; or

d. Provide the podiatric medical graduate with clinical experience necessary to become competent in the full scope of advanced podiatric medicine and surgery.

3. "Podiatric medicine" means the profession of the health services concerned with the diagnosis and treatment of conditions affecting the human foot and ankle ~~and their governing and related structures~~ including local manifestations of systemic conditions by all appropriate systems and means and includes the prescribing or administering of drugs or medications necessary or helpful to that profession.

4. "Podiatrist" means a person who is qualified or authorized to practice podiatric medicine in North Dakota.

5. "Preceptorship" means a formal, structured postdoctoral training program, with written objectives appropriate to all aspects of the program and a written evaluation process, conducted by a podiatrist primarily in an office-based setting and controlled and supervised by a college of podiatric medicine accredited by the council on podiatric medical education or the American podiatric medical association. The preceptorship must provide the recent podiatric medical graduate sufficient experiences to have further patient care exposure, to improve clinical management and communication skills, and to obtain increased self-confidence. Preceptor requirements must include the following:

   a. Provide training in the care of children and adults that offers experience as defined by the statutory scope of practice including drug therapy, radiology, local anesthesia, analgesia, biomechanics, physical medicine, rehabilitation, and the following surgeries:

      (1) Nail;

      (2) Digital;

      (3) Soft tissue;

      (4) Forefoot;

      (5) Metatarsal;

      (6) Midfoot; and

      (7) Rearfoot or ankle ~~and related and governing structures~~.

   b. Hold a clinical appointment at a podiatric medical school or be a member of the teaching staff of a hospital sponsoring a residency program.

c. Have a hospital staff appointment with podiatric surgical privileges; however, the granting of staff privileges is solely within the discretion of individual institutions; and

d. Not have been the subject of disciplinary action concerning professional conduct or practice.

6. "Title" or "this title" means title 63 of the North Dakota Administrative Code.

History: Effective December 1, 1991; amended effective January 1, 1998.
General Authority: NDCC 43-05-08
Law Implemented: NDCC 43-05-01, 43-05-11

63-02-03-02. License display. Every podiatrist to whom an annual license has been issued shall keep the license conspicuously in one's office or place of business, and shall whenever required exhibit the license to any member or representative of the board. If a licensee has more than one office or place of business, official duplicates of the current annual license must be obtained and prominently displayed in each office. ~~A fee of ten dollars for each such duplicate must be paid by the podiatrist.~~

History: Effective October 1, 1982; amended effective December 1, 1991; January 1, 1998.
General Authority: NDCC 28-32-02, 43-05-08
Law Implemented: NDCC 43-05-09

CHAPTER 63-02-08

63-02-08-01. Fees. All remittances must be made payable to the North Dakota board of podiatric medicine and must be paid in United States money and are not refundable except as otherwise provided in section 63-02-08-02. The type of fees and amounts are:

1.	Application fee	$150
2.	Application fee based on reciprocity	150
3.	Temporary license fee	150
4.	Delinquent renewal fee	25
5.	Relicensure fee	150
6.	Annual license fee or annual license renewal fee	~~200~~ 500
7.	Temporary permit fee	200
8.	Reexamination license fee	300
9.	Duplicate/replacement fee	10 for each

History: Effective October 1, 1982; amended effective December 1, 1991; October 18, 1996.
General Authority: NDCC 28-32-02, 43-05-08
Law Implemented: NDCC 43-05-08, 43-05-10, 43-05-12, 43-05-13, 43-05-14, 43-05-15

TITLE 73

Securities Commissioner

JANUARY 1998

ARTICLE 73-01

GENERAL ADMINISTRATION

[Repealed effective January 1, 1998]

CHAPTER 73-02-01

73-02-01-01. Small corporate offering registration.

1.--Preliminary--notes.---This--chapter--is--intended-to-encourage investment--in--small--businesses.---This--chapter--offers--an optional--method--of--registration--for--corporations--issuing securities-exempt-from-registration-with--the--securities--and exchange--commission--under--rule-504-of-Regulation-D-or-under section--3(a)(11)--of--the--Securities--Act--of---1933.----The commissioner--recognizes--that--small--issuers--raising--small amounts-of-money-face-special-problems-not--faced--by--issuers raising--larger--amounts,--and--that--standards-appropriate-to registrations-of-larger-offerings-may-become-unduly-burdensome when---applied--to--registrations--of--small--offerings.---The optional--registration--method--offered--by--this--chapter--is intended--to--reduce--the-costs-and-burdens-of-raising-capital for-small-business-without--sacrificing--investor--protection, and--to--maximize-the-amount-of-offering-proceeds-available-to the-issuer-for-investment-in-the-business.---Issuers--eligible for--this--method--of--registration-shall-use-the-registration form-SCOR-as-the-disclosure-document-for-the--offering.---This method-of-registration-must-be-known-as-SCOR-registration.

2.--Application.

a.--This---chapter---applies--to--SCOR--registrations.---While applications-not-conforming--to--the--standards--contained herein-will-be-looked-upon-with-disfavor,-where-good-cause is-shown,-certain-rules-may-be-modified-or-waived--by--the commissioner.

b.--Where--individual--characteristics--of--specific-offerings warrant-modification-from-these-standards,--they--will--be accompanied,---insofar--as--possible,--while--still--being consistent-with-the-spirit-of-this-chapter.

3.--Availability.

a.--This--chapter--is--available--only--to--the--issuer-of-the securities-and-not-to-any-affiliate-of-that-issuer--or--to any--other--person--for-resale-of-the-issuer's-securities. In-addition,-each-of-the-following--requirements--must--be met:

(1)--The--issuer-must-be-a-corporation-organized-under-the laws-of-one-of--the--states--or--possessions--of--the United-States.

(2)--The--issuer--must--engage--in--a--business-other-than petroleum-exploration--or--production--or--mining--or other-extractive-industries.

(3)--The--offering--is--not-a-blind-pool-or-other-offering for-which-the-specific-business-to-be-engaged--in--or property--to--be--acquired--by--the--issuer-cannot-be specified.

(4)--The-offering-price-for-common-stock-(and-the-exercise price,--if--the--securities--offered---are---options, warrants---or---rights--for--common--stock,--and--the conversion-price-if-the--securities--are--convertible into--common--stock)-must-be-equal-to-or-greater-than five-dollars-per-share.

(5)--The---aggregate--offering--price--of--the--securities offered,-within-or-outside-this-state,-may-not-exceed one-million-dollars-less-the-aggregate-offering-price of-all--securities--sold--within--the--twelve--months before--the--start--of-and-during-the-offering-of-the securities-under-securities-and--exchange--commission rule-504---in---reliance---on---any--exemption--under section-3(b)--of--the--Securities--Act--of--1933,--in reliance--on--the-exemption-under-section-3(a)(11)-of that-Act,-or-in-violation--of--section-5(a)--of--that Act.

b.--SCOR-registration-is-not-available-to-investment-companies subject-to-the-Investment-Company-Act-of-1940,-nor--is--it available-to-issuers-subject-to-the-reporting-requirements of-section-13-or-section-15(d)-of-the-Securities--Exchange Act-of-1934.

c.--SCOR--is-available-for-registration-of-debt-offerings-only if--the--issuer--can--demonstrate--reasonable--ability--to service-its-debt.

4.--Disqualification---from---use---of--SCOR--registration.---SCOR registration-is-not-available-for-securities-of-any-issuer--if that--issuer--or--any--of-its-officers,-directors,-ten-percent stockholders,--promoters,--or--any--selling--agents---of---the securities-to-be-offered,-or-any-officer,-director,-or-partner of-such-selling-agent:

a.--Has-filed-a-registration-statement-which-is-the-subject-of a-currently--effective--registration--stop--order--entered pursuant--to--any--federal--or-state-securities-law-within five-years-prior-to-the-filing-of--the--SCOR--registration application;

b.--Has--been--convicted-within-five-years-prior-to-the-filing of-the-SCOR-registration--application--of--any--felony--or

misdemeanor in connection with the offer, purchase or sale of any security or any felony involving fraud or deceit, including, but not limited to, forgery, embezzlement, obtaining money under false pretenses, larceny, or conspiracy to defraud;

c. Is currently subject to any state administrative enforcement order or judgment entered by any state securities administrator or the securities and exchange commission within five years prior to the filing of the SCOR registration application or is subject to any federal or state administrative enforcement order or judgment in which fraud or deceit, including, but not limited to, making untrue statements of material facts and omitting to state material facts, was found and the order or judgment was entered within five years prior to the filing of the SCOR registration application;

d. Is subject to any state's administrative enforcement, order, or judgment which prohibits, denies, or revokes the use of any exemption for registration in connection with this offer, purchase, or sale of securities; or

e. Is currently subject to any order, judgment, or decree of any court of competent jurisdiction temporarily or preliminarily restraining or enjoining, or is subject to any order, judgment, or decree of any court of competent jurisdiction, permanently restraining or enjoining such party from engaging in or continuing any conduct or practice in connection with the purchase or sale of any security or involving the making of any false filing with any state or with the securities and exchange commission entered within five years prior to the filing of the SCOR registration application; provided, however, the prohibition of this subdivision and subdivisions a through e of this subsection do not apply if the person subject to the disqualification is duly licensed or registered to conduct securities related business in the state in which the administrative order or judgment was entered against such person or if the dealer employing such party is licensed or registered in this state and the form BD filed in this state discloses the order, conviction, judgment, or decree relating to such person. No person disqualified under this section may act in any capacity other than that for which the person is licensed or registered. Any disqualification caused by this subsection is automatically waived if the state securities administrator or other state or federal agency which created the basis for disqualification determines upon a showing of good cause that it is not necessary under the circumstances that the exemption be denied.

5.--Agreement--by--registrant-on-stock-splits-and-stock-dividends. By-filing-for-SCOR-registration-in-this-state,-the--registrant agrees--with--the--commissioner--that--the-registrant-will-not split-its-common-stock,-or-declare-a-stock-dividend,--for--two years--after-the-effectiveness-of-the-registration-without-the prior-written-approval-of-the-commissioner.

6.--Documents--to--be--filed-with-commissioner-by-SCOR-registrant. In--addition--to--filing--a--properly--completed--SCOR---form, applicants--for--SCOR--registration--shall--file-the-following exhibits-with-the-commissioner:

a.--Form-of-selling-agency-agreement;

b.--The--issuer's--articles--of-incorporation-or-other-charter documents-and-all-amendments-thereto;

c.--The-issuer's-bylaws,-as-amended-to-date;

d.--Copy--of--any-resolutions-by-directors-setting-forth-terms and-provisions-of-capital-stock-to-be-issued;

e.--Any-indenture,-form-of-note-or-other-contractual-provision containing-terms-of-notes-or-other-debt,--or--of--options, warrants,-or-rights-to-be-offered;

f.--Specimen--of--security-to-be-offered,-including-any-legend restricting-resale;

g.--Consent--to--service-of-process-accompanied-by-appropriate corporate-resolution;

h.--Copy--of--all-advertising-or-other-material-directed-to-or to-be-furnished-investors-in-the-offering;

i.--Form-of-escrow-agreement-for-escrow-of-proceeds;

j.--Consent---to---inclusion---in---disclosure---document---of accountant's-report;

k.--Consent---to--inclusion--in--disclosure--document--of--tax adviser's-opinion-or-description-of-tax-consequences;

l.--Consent---to--inclusion--in--disclosure--document--of--any evaluation--of--litigation--or--administrative--action--by counsel;

m.--Form--of--any--subscription--agreement-for-the-purchase-of securities-in-this-offering;

n.--Opinion--of--attorney--licensed--to-practice-in-a-state-or territory-of-the-United-States-that-the-securities--to--be sold--in--the--offering-have-been-duly-authorized-and-when

~~issued upon payment of the offering price will be legally and validly issued, fully paid and nonassessable, and binding on the issuer in accordance with their terms; and~~

~~e. Schedule of residence street addresses of officers, directors, and principal stockholders.~~ Small corporate offering registration (SCOR) filings may be used for registration applications and exemption applications for corporations that issue securities exempt from federal registration under rule 504 of regulation D of the securities and exchange commission rules. Form U-7, as adopted by the North American securities administrators association, inc., on April 29, 1989, is adopted for this purpose.

History: Effective September 1, 1990; amended effective January 1, 1998.
General Authority: NDCC 10-04-03
Law Implemented: NDCC 10-04-03

73-02-02-04. Approval of Chicago board options exchange, the Pacific stock exchange, and the Philadelphia stock exchange. The Chicago board options exchange, incorporated, ~~is~~ tier 1 of the Pacific stock exchange, incorporated, and tier 1 of the Philadelphia stock exchange, incorporated, are approved for purposes of the marketplace exemption ~~as set forth~~ in subsection ~~16~~ 15 of North Dakota Century Code section 10-04-05.

History: Effective May 1, 1992; amended effective January 1, 1998.
General Authority: NDCC 10-04-05(16)
Law Implemented: NDCC 10-04-05(16)

CHAPTER 73-02-03

73-02-03-01. Limited offeree exemption.

~~1.--Application--form.--Except-as-otherwise-specifically-provided,-application-for-approval--of--the--limited--offeree--exemption under--subdivision-a--of--subsection-9-of-North-Dakota-Century Code-section-10-04-06-shall-be-made-on-the--form--attached--to this-section,-which-is-incorporated-herein-by-reference.~~

~~2.--Supplemental---filings.----In---addition--to--the--information specified-in-the-application,-the-commissioner-may-require-the filing----of---such---supplemental---schedules,---projections, appraisals,-opinions,-documents,-memoranda,-briefs,--or--other matter--as--the-commissioner-deems-convenient,-appropriate,-or necessary-to--determine--whether--the--application--should--be approved.~~

~~3.--Filing-fee.--Except-as-otherwise-specifically-provided,-the~~ An offeree may apply for the limited offeree exemption under subdivision a of subsection 9 of section 10-04-06 of the North Dakota Century Code by filing an application form ~~shall--be accompanied--by~~ and a nonrefundable filing fee of one hundred dollars.

~~4.--Term-of-effectiveness.--Unless-earlier-suspended-or-revoked-or unless-otherwise-limited-or-restricted--by--the--commissioner, approval~~ Approval under this section shall be effective for ~~the-period-of-twelve-consecutive--months--beginning--with--the date--of--the--letter--by--which--approval--is-granted.--A-new application--must--be--filed--with---and---approved---by---the commissioner-if-offers-or-sales-will-extend-beyond-the-twelve-month-period~~ one year.

~~5.--Conditions.---The--commissioner--may--place--such--conditions, limitations,--or--restrictions--on--this--exemption---as---the commissioner--deems--appropriate-or-necessary-to-carry-out-the purposes-of-the-Securities-Act-of-1951.~~

~~6.--Reports.~~ Within thirty days after the completion of the offering or expiration of the twelve-month approval period, whichever occurs first, the offeror shall file a report of all offers and sales in this state on a form prescribed by the commissioner.

~~7.--Waiver.~~

~~a.--Except--as--otherwise-provided-under-subdivisions-c-and-d, if-the-number-of-offerees-in-connection-with-all-offers-of securities,--whether--of-the-same-or-of-a-different-issue, in-this-state-during-a-consecutive-twelve-month-period--is~~

three-or-fewer-and-if-the-conditions-in-paragraphs-1-and-2 of-subdivision-a-of-subsection-9-of-North--Dakota--Century Code--section-10-04-06-are-met,-the-application,-approval, filing-fee,-and-reporting--requirements--prescribed--under this-section-are-waived.

b.---In-addition-to-the-waiver-of-the-filing-fee-provided-under subdivision-a,-the-commissioner-may-also-waive-the--filing fee--in--any--other-case-where-the-commissioner-determines that-the--time--and--effort--involved--in--processing--the application-do-not-justify-the-imposition-of-the-fee.

c.---The--waiver--provided--under-subdivision-a-shall-not-apply where-any-person-involved-in-the-offering,-either-directly or--indirectly,--as-promoter,-issuer,-underwriter,-broker-dealer,-salesman,-investment--adviser,--partner,--officer, director,--manager,--controlling--shareholder,--or--in-any similar-capacity-or-position:

(1)--Has---been---suspended,---expelled,---fined,--barred, censured,-or-otherwise-disciplined-by-any-securities, insurance,---banking,--real--estate,--or--commodities agency,--jurisdiction,--or--organization;---or---been refused----membership---therein---or---withdrawn---an application-for-such-membership,-or-been--refused--or denied-a-license-or-registration-or-had-one-suspended or-revoked--by--any--such--agency,--jurisdiction,--or organization--or-by-any-other-business-or-profession; or--has--knowledge--of--being--the--subject--of---any investigation--or--proceeding--by--any--such--agency, jurisdiction,--or--organization--or--by---any---other business-or-profession.

(2)--Has-been-the-subject-of-or-has-been-associated-in-any capacity-with-another-person-against-whom-a-temporary restraining-order,-temporary-or-permanent-injunction, cease-and-desist-order,-or--similar--order--has--been issued--either--by--a--court--or-by-an-administrative agency.

(3)--Has--been--arrested-for,-complained-against,-informed against,-or-indicted-for,-convicted--of,--or--pleaded nolo--contendere-to-any-felony-or-misdemeanor,-except minor-traffic-offenses.

(4)--Is--now--or-has-been-a-defendant-or-respondent-in-any litigation-or-proceeding-alleging--the--violation--of any--securities,--insurance,-banking,-real-estate,-or commodities-law-or-regulation.

(5)--Has--been--associated--with-any-firm,-corporation,-or association-which-has--failed--in--business,--made--a compromise--with--creditors,--filed--or-been-declared

bankrupt-under-any-bankruptcy-acts,-or--for--which--a trustee--has--been--appointed--under--the--Securities Investor-Protection-Act-of-1970-[Pub.-L.--91-598;--84 Stat.--1636;-15-U.S.C.-78aaa-et-seq.],-as-amended,-or which---has---been---liquidated---under---any---other circumstances.

(6)--Has---been---suspended,---expelled,---fined,--barred, censured,-or-otherwise-disciplined-by-an-employer--in the--securities,--insurance,-banking,-real-estate,-or commodities--industry;--or---in---previous---business connections--or--employment--has--been-a-subject-of-a major-complaint--or--legal--proceeding--or--has--been discharged--or--requested--to--resign--by-an-employer because-of-dishonest-or-unethical-acts.

d. Paragraph 3 of subdivision a of subsection 9 of section 10-04-06 of the North Dakota Century Code is waived for the following transactions:

1. If--the A security is issued by a-corporation-engaged-in-the business-of-farming--or--ranching--which--is an organization organized under and operated in compliance with North-Dakota Century-Code chapter 10-06,-the-permissible-number-of-offerees in--this--state-during-a-consecutive-twelve-month-period-shall not-exceed-fifteen,-and-the-conditions-in-paragraphs-1,-2,-and 3--of--subdivision-a--of--subsection-9-of-North-Dakota-Century Code-section-10-04-06-and-the--application,--approval,--filing fee,--and-reporting-requirements-prescribed-under-this-section are-waived 10-06.1 of the North Dakota Century Code, and offered or sold in compliance with that chapter. The provisions of paragraphs 1 and 2 of subdivision a of subsection 9 of section 10-04-06 of the North Dakota Century Code are waived for this transaction.

2. An offer or sale of securities by an organization that is organized and registered with the secretary of state of this state if all sales are completed on or before the first effective date of the initial organization or initial registration with the secretary of state of this state.

History: Amended effective August 1, 1980; July 1, 1981; November 1, 1981; July 1, 1987; August 1, 1987; September 1, 1990; January 1, 1998.
General Authority: NDCC 10-04-06(9)
Law Implemented: NDCC 10-04-06(9)

73-02-03-02. North Dakota issuer exemption.

1.--Application----form.-----The----application---required---under subdivision-b-of-subsection-9-of--North--Dakota--Century--Code section--10-04-06--must--be--made-on-the-form-attached-to-this section,-which-is-incorporated-herein-by-reference.

2.--Supplemental---filings.----In---addition--to--the--information specified-in-the-application,-the-commissioner-may-require-the filing----of---such---supplemental---schedules,---projections, appraisals,-opinions,-documents,-memoranda,-briefs,--or--other matter--as--the-commissioner-deems-convenient,-appropriate,-or necessary-to-carry-out-the-purposes-of-the-Securities--Act--of 1951.

3.--Term-of-effectiveness.--Unless-earlier-suspended-or-revoked-or unless-otherwise-limited-or-restricted--by--the--commissioner, this---exemption---is--effective--for--the--period--of--twelve consecutive-months-beginning-with-the-date-of--the--letter--by which-approval-is-granted.--A-new-application-must-be-filed-if sales-will-extend-beyond-the-twelve-month-period.

4.--Conditions.---The--commissioner--may--place--such--conditions, limitations,--or--restrictions--on--this--exemption---as---the commissioner--deems--appropriate-or-necessary-to-carry-out-the purposes-of-the-Securities-Act-of-1951.

5.--Reports.---Within--thirty--days--after--the--completion-of-the offering-or-expiration-of-the--twelve-month--approval--period, whichever--occurs--first,--the--issuer--shall-file-a-report-of sales-on-a-form-prescribed-by-the-commissioner.

6.--Disqualifications.

a.--Except---as--otherwise--provided--in--subdivision-b,--this exemption-is-not-available-where-any--person--involved--in the--offering,-either-directly-or-indirectly,-as-promoter, issuer,-underwriter,-broker-dealer,--salesman,--investment adviser,---investment---adviser--representative,--partner, officer,-director,-manager,-controlling-shareholder,-or-in any-similar-capacity-or-position:

(1)--Has---been---suspended,---expelled,---fined,--barred, censured,-or-otherwise-disciplined-by-any-securities, insurance,---banking,--real--estate,--or--commodities agency,--jurisdiction,--or--organization;---or---been refused----membership---therein---or---withdrawn---an application-for-such-membership;-or-been--refused--or denied-a-license-or-registration-or-had-one-suspended or-revoked--by--any--such--agency,--jurisdiction,--or organization--or-by-any-other-business-or-profession; or--has--knowledge--of--being--the--subject--of---any investigation--or--proceeding--by--any--such--agency, jurisdiction,--or--organization--or--by---any---other business-or-profession.

(2)--Has-been-the-subject-of-or-has-been-associated-in-any capacity-with-another-person-against-whom-a-temporary restraining-order,-temporary-or-permanent-injunction, cease-and-desist-order,-or--similar--order--has--been

issued--either--by--a--court--or-by-an-administrative agency.

(3)--Has--been--arrested-for,-complained-against,-informed against,-or-indicted-for,-convicted--of,--or--pleaded nolo--contendere-to-any-felony-or-misdemeanor,-except minor-traffic-offenses.

(4)--Is--now--or-has-been-a-defendant-or-respondent-in-any litigation-or-proceeding-alleging--the--violation--of any--securities,--insurance,-banking,-real-estate,-or commodities-law-or-regulation.

(5)--Has--been--associated--with-any-firm,-corporation,-or association-which-has--failed--in--business,--made--a compromise--with--creditors,--filed--or-been-declared bankrupt-under-any-bankruptcy-acts,-or--for--which--a trustee--has--been--appointed--under--the--Securities Investor-Protection-Act-of-1970-[Pub.-L.--91-598,--84 Stat.--1636,-15-U.S.C.-78aaa-et-seq.],-as-amended,-or which---has---been---liquidated---under---any---other circumstances.

(6)--Has---been---suspended,---expelled,---fined,--barred, censured,-or-otherwise-disciplined-by-an-employer--in the--securities,--insurance,-banking,-real-estate,-or commodities--industry,--or---in---previous---business connections--or--employment--has--been-a-subject-of-a major-complaint--or--legal--proceeding--or--has--been discharged--or--requested--to--resign--by-an-employer because-of-dishonest-or-unethical-acts.

b.--Subdivision-a---does--not--apply--to--any--issuer--if--the commissioner-determines,-upon-a--showing--of--good--cause, that--it--is--not--necessary--or-appropriate-in-the-public interest-or-for--the--protection--of--investors--that--the exemption--be--denied.---Any-such-determination-is-without prejudice-to-any-other-action-by-the-commissioner--in--any other--proceeding--or-matter-with-respect-to-the-issuer-or any-other-person.

7.--Security--transfer.---Securities--purchased--pursuant--to-this exemption-must-be-held-by-the-purchaser-for-a--period--of--two years-from-the-date-of-purchase-from-the-issuer,-except-that-a purchaser-at-any-time-may-transfer-such-security:

a.--To-the-issuer,-or-to-a-director-or-officer-of-the-issuer;

b.--To--any--relative,--spouse,-or-relative-of-a-spouse-of-the purchaser-who-has-the--same--principal--residence--as--the purchaser;

~~c.--To--a--corporation--or--other--organization--in--which-the purchaser--and---any---of---the---persons---specified---in subdivision-b--own--one--hundred--percent--of--the--equity securities;~~

~~d.--To--any--trust-or-estate-in-which-the-purchaser-and-any-of the-persons-specified-in--subdivision-b--own--one--hundred percent-of-the-beneficial-interest;-or~~

~~e.--To--a--trust--in--which--the--purchaser--has-a-one-hundred percent--beneficial--interest---during---the---purchaser's lifetime.~~

~~The--foregoing--transferees-are-subject-to-the-restrictions-on transfer-contained--in--this--subsection,--provided--that--the two-year-holding-period-begins-on-the-date-the-securities-were first-purchased-from-the-issuer.--A-legend-must-be-placed-upon certificates--for--the--security--purchased--pursuant--to-this exemption-referring-to-the-restrictions-on-transfer--contained in-this-subsection.~~

1. An issuer located in North Dakota may apply for a one-year exemption under subdivision b of subsection 9 of section 10-04-06 of the North Dakota Century Code. Except as otherwise provided, this exemption is not available if any person involved in the offering, either directly or indirectly, as promoter, issuer, underwriter, broker-dealer, salesman, investment adviser, investment adviser representative, partner, officer, director, manager, controlling shareholder, or in any similar capacity or position:

   a. Has been suspended, expelled, fined, barred, censured, or otherwise disciplined by any securities, insurance, banking, real estate, or commodities agency, jurisdiction, or organization; has been refused membership therein or withdrawn an application for such membership; has been refused or revoked by any such agency, jurisdiction, or organization or by any other business or profession; or has knowledge of being the subject of any current or continuing investigation or proceeding by any such agency, jurisdiction, or organization or by any other business or profession.

   b. Has been the subject of or has been associated in any capacity with another person against whom a temporary restraining order, temporary or permanent injunction, cease and desist order, or similar order has been issued either by a court or by an administrative agency.

   c. Has been arrested for, complained against, informed against, or indicted for, convicted of, or pleaded

nolo contendre to any felony or misdemeanor, except minor traffic offenses.

d. Is now or has been a defendant or respondent in any litigation or proceeding alleging the violation of any securities, insurance, banking, real estate, or commodities law or regulations.

e. Has been associated with any firm, corporation, or association which has failed in business, made a compromise with creditors, filed or been declared bankrupt under any bankruptcy acts, or for which a trustee has been appointed under the Securities Investor Protection Act of 1970 [Pub. L. 91-598; 84 Stat. 1636; 15 U.S.C. 78aaa et seq.], as amended, or which has been liquidated under any other circumstances.

f. Has been suspended, expelled, fined, barred, censured, or otherwise disciplined by an employer in the securities, insurance, banking, real estate, or commodities industry or in previous business connections or employment has been a subject of a complaint or legal proceeding involving a client or customer or has been discharged or requested to resign by an employer because of dishonest or unethical acts.

The above does not apply to any issuer if the commissioner determines, upon a showing of good cause, that it is not necessary or appropriate in the public interest or for the protection of investors that the exemption be denied. Any such determination is without prejudice to any other action by the commissioner in any other proceeding or matter with respect to the issuer or any other person.

2. The exempted securities must be held by the purchaser for one year from the date of purchase from the issuer, except that a purchaser at any time may transfer such security:

a. To the issuer, or to a director or officer of the issuer;

b. To any relative, spouse, or relative of a spouse of the purchaser who has the same principal residence as the purchaser;

c. To a corporation or other organization in which the purchaser and any of the persons specified in subdivision b own one hundred percent of the equity securities;

d. To any trust or estate in which the purchaser and any of the persons specified in subdivision b own one hundred percent of the beneficial interest; or

e. To a trust in which the purchaser has a one hundred percent beneficial interest during the purchaser's lifetime.

Transferees are subject to the restrictions on transfer if the one-year holding period begins on the date the securities were first purchased from the issuer and the certificates shall describe the restrictions on transfer. Within thirty days after the completion of the offering or expiration of the twelve-month approval period, whichever occurs first, the offeror shall file a report of all offers and sales in this state on a form prescribed by the commissioner.

History: Effective July 1, 1987; amended effective September 1, 1990; January 1, 1998.
General Authority: NDCC 10-04-06(9)
Law Implemented: NDCC 10-04-06(9)

73-02-03-03. Uniform limited offering exemption.

~~1.--Preliminary-notes.~~

~~a.--Nothing--in--this--exemption--is--intended-to-or-should-be construed-as-in--any--way--relieving--issuers--or--persons acting--on--behalf-of-issuers-from-providing-disclosure-to prospective-investors-adequate-to--satisfy--the--antifraud provisions-of-this-state's-securities-laws.~~

~~b.--In--view-of-the-objective-of-this-section-and-the-purposes and-policies-underlying-this-Act,--the--exemption--is--not available--to--any--issuer-with-respect-to-any-transaction which,-although-in-technical-compliance-with-this-section, is--part--of-a-plan-or-scheme-to-evade-registration-or-the conditions--or--limitations--explicitly--stated--in---this section.~~

~~c.--Nothing--in-this-section-is-intended-to-relieve-registered dealers-or-salesmen-from-the-due--diligence,--suitability, or--know-your-customer-standards-or-any-other-requirements of-law-otherwise-applicable-to-such-registered-persons.~~

~~2.--Exemption.---The--following--transaction--is--determined-to-be exempt-from-the-registration--provisions--contained--in--North Dakota--Century--Code--chapter--10-04.---Any--offer-or-sale-of securities-offered-or-sold-in-compliance-with--Securities--Act of--1933,--Regulation-D,-rules-230.505,-including-any-offer-or sale-made--exempt--by--application--of--rule-508(a),--as--made effective--in--release--no.-33-6389--and-as-amended-in-release nos.-33-6437,--33-6663,--33-6758,--and--33-6825,---and---which satisfies-the-following-further-conditions-and-limitations:~~

~~a.--No--commission,--fee,-or-other-remuneration-may-be-paid-or given,--directly--or--indirectly,--to---any---person---for~~

soliciting any prospective purchaser in this state unless such person is appropriately registered in this state.

b. No exemption under this section is available for the securities of any issuer if any of the parties described in Securities Act of 1933, Regulation A, rule 230.252, sections (c), (d), (e), or (f):

(1) Has filed a registration statement which is the subject of a currently effective registration stop order entered pursuant to any state's securities law within five years prior to the filing of the notice required under this exemption.

(2) Has been convicted within five years prior to the filing of the notice required under this exemption of any felony or misdemeanor in connection with the offer, purchase, or sale of any security or any felony involving fraud or deceit, including, but not limited to, forgery, embezzlement, obtaining money under false pretenses, larceny, or conspiracy to defraud.

(3) Is currently subject to any state administrative enforcement order or judgment entered by that state's securities administrator within five years prior to the filing of the notice required under this exemption or is subject to any state's administrative enforcement order or judgment in which fraud or deceit, including, but not limited to, making untrue statements of material facts and omitting state material facts, was found and the order or judgment was entered within five years prior to the filing of the notice required under this exemption.

(4) Is subject to any state's administrative enforcement order or judgment which prohibits, denies, or revokes the use of any exemption from registration in connection with the offer, purchase, or sale of securities.

(5) Is currently subject to any order, judgment, or decree of any court of competent jurisdiction temporarily or preliminarily restraining or enjoining, or is subject to any order, judgment, or decree of any court of competent jurisdiction, permanently restraining or enjoining, such party from engaging in or continuing any conduct or practice in connection with the purchase or sale of a security or involving the making of any false filing with the state entered within five years prior to the filing of the notice required under this exemption.

(6) The prohibitions of paragraphs 1, 2, 3, and 5 do not apply if the person subject to the disqualification is duly licensed or registered to conduct securities related business in the state in which the administrative order or judgment was entered against such person or if the dealer employing such party is licensed or registered in this state and the form B D filed with this state discloses the order, conviction, judgment, or decree relating to such person. No person disqualified under this subdivision may act in a capacity other than that for which the person is licensed or registered.

(7) Any disqualification caused by this subdivision is automatically waived if the commissioner or agency of the state which created the basis for disqualification determines upon showing of good cause that it is not necessary under the circumstances that the exemption be denied. It is a defense to a violation of this subsection if the issuer sustains the burden of proof to establish that the issuer did not know and in the exercise of reasonable care could not have known that a disqualification under this subsection existed.

e. The issuer shall file with the commissioner a notice on form D (17 CFR 239.500).

(1) No later than ten days prior to the receipt of consideration or the delivery of a subscription agreement to an investor in this state which results from an offer being made in reliance upon this exemption and at such other times and in the form required under Regulation D, rule 230.503 to be filed with the securities and exchange commission. This notice must be accompanied by one copy of any written information furnished to investors and a consent to service of process.

(2) Every person filing the initial notice provided for in paragraph a of this subdivision shall pay a filing fee of one hundred dollars.

d. In all sales to nonaccredited investors in this state, one of the following conditions must be satisfied or the issuer and any person acting on its behalf shall have reasonable grounds to believe, and after making reasonable inquiry, shall believe that one of the following conditions is satisfied:

(1) The investment is suitable for the purchaser upon the basis of the facts, if any, disclosed by the purchaser as to the purchaser's other security

holdings, financial situation, and needs. For the purpose of this condition only, it may be presumed that if the investment does not exceed ten percent of the investor's net worth, it is suitable.

(2) The purchaser, either alone or with the purchaser's representative, has such knowledge and experience in financial and business matters that the purchaser is or they are capable of evaluation the merits and risks of the prospective investment.

3. A failure to comply with a term, condition, or requirement of subdivisions a, c, and d of subsection 2 will not result in loss of the exemption from the requirements of North Dakota Century Code section 10-04-04 for any offer or sale to a particular individual or entity if the person relying on the exemption shows:

a. The failure to comply did not pertain to a term, condition, or requirement directly intended to protect that particular individual or entity;

b. The failure to comply was insignificant with respect to the offering as a whole; and

c. A good faith and reasonable attempt was made to comply with all applicable terms, conditions, and requirements of subdivisions a, c, and d of subsection 2.

4. Where an exemption is established only through reliance upon this subsection, the failure to comply is nonetheless actionable by the commissioner under North Dakota Century Code section 10-04-16.

5. Transactions which are exempt under this section may not be combined with offers and sales exempt under any other rule or provision of North Dakota Century Code chapter 10-04; however, nothing in this limitation acts as an election. Should, for any reason, the offer and sale fail to comply with all the conditions for this exemption, the issuer may claim the availability of any other applicable exemption.

6. The commissioner may, by rule or order, waive any conditions of this exemption. Repealed effective January 1, 1998.

History: Effective September 1, 1990.
General Authority: NDCC 10-04-06(9)(c)
Law Implemented: NDCC 10-04-06(9)(c)

CHANPTER 73-02-04

73-02-04-02. Tender offers. ~~Advertising--matter--relating--to tender-offers-for-securities,-other-than-exempt-securities--under--North Dakota---Century---Code--section--10-04-05,--shall--be--filed--with--the commissioner-in-accordance-with-subsection-1--of--North--Dakota--Century Code-section-10-04-08.2.~~ Repealed effective January 1, 1998.

General Authority: ~~NDCC-10-04-08.2(2)~~
Law Implemented: ~~NDCC-10-04-08.2(1)~~

CHAPTER 73-02-09

73-02-09-01. Fraudulent practices ~~of-dealers-and-sales-agents. The-purpose-of-this-section-is-to-identify-practices-in--the--securities business--which--are-generally-associated-with-schemes-to-manipulate.~~ A ~~dealer-or-sales-agent~~ person who engages in one or more of the following practices ~~must--be--deemed-to-have~~ has engaged in an "act, practice, or course of business which operates or would operate as a fraud" as--used ~~in~~ under North Dakota Century Code section 10-04-15.~~---This-section-is not-intended-to-be-all-inclusive,-and-thus,~~ but acts or practices not ~~enumerated--herein~~ described in this rule may also be ~~deemed~~ fraudulent.

1. Entering into a transaction with a customer in any security at an ~~unreasonable~~ excessive price or at a price not reasonably related to the current market price of the security or receiving an ~~unreasonable~~ excessive commission or profit under the rules of the national association of securities dealers.

2. Contradicting or negating the importance of any information contained in a prospectus or other offering materials with intent to deceive or mislead or using any advertising or sales presentation in a deceptive or misleading manner.

3. ~~In~~ For any person, in connection with the offer, sale, or purchase of a security, ~~falsely-leading~~ or the recommendation of an offer, sale, or purchase of a security, to lead a customer to believe that the ~~broker-dealer-or-agent~~ person is in possession of material, nonpublic information which would impact on the value of the security.

4. In connection with the solicitation of a sale or purchase of a security, engaging in a pattern or practice of making contradictory recommendations to different investors ~~of~~ who have similar investment ~~objective~~ objectives for some investors to sell and others to purchase the same security, at ~~or-about~~ approximately the same time, when not justified by the particular circumstance of each investor.

5. Failing to make a bona fide public offering of all the securities allotted to a broker-dealer for distribution by, ~~among-other-things,-(a)-transferring:~~

   a. Transferring securities to a customer, another broker-dealer, or a fictitious account with the understanding that those securities will be returned to the broker-dealer or its nominees ~~or-(b)-parking;~~

   b. Parking, hiding, delaying, or withholding securities from trading; or

c. Engaging in any unreasonable delay in delivery of securities purchased by any customers or in the payment upon request of free credit balances.

6. Although nothing in this section precludes application of the general antifraud provisions against anyone for practices similar in nature to the practices discussed in this subsection, the following subsections specifically apply only in connection with the solicitation of a purchase or sale of over the counter ~~non-national~~ equity securities that are not listed on the national association of securities dealers automated quotation system ~~equity-securities~~ (NASDAQ):

   a. Failing to disclose the firm's present bid and ask price of a particular security at the time of solicitation; and ~~the--firm's--bid-and-ask-price-at-the-time-of-execution-on~~ the confirmation.

   b. Failing to advise the customer, both at the time of solicitation and on the confirmation, of any and all compensation related to a specific securities transaction to be paid to the agent including commissions, sales charges, or concessions.

   c. In connection with a principal transaction, failing to disclose, both at the time of solicitation and ~~on--the~~ confirmation, a short inventory position in the firm's account of more than five percent of the issued and outstanding shares of the class of securities of the issuer~~;-provided-that,-this-subsection-applies-only~~ if the firm is a market maker at the time of the solicitation.

   d. Conducting sales contests in a particular security.

   e. After a solicited purchase by a customer, failing or refusing, in connection with a principal transaction, to promptly execute sell orders.

   f. Soliciting a secondary market transaction when there has not been a bona fide distribution in the primary market.

   g. Engaging in a pattern of compensating an agent in different amounts for effecting sales and purchases in the same security.

7. Effecting any transaction in, or inducing the purchase or sale of any security by means of any manipulative, deceptive, or other fraudulent ~~device--or--contrivance~~ scheme or course of actions including, but not limited to, the use of boilerroom tactics or use of fictitious or nominee accounts.

8. Failure to ~~comply--with--any~~ deliver a prospectus ~~delivery requirement promulgated under~~ as required by federal law.

History: Effective September 1, 1990; amended effective January 1, 1998.
General Authority: NDCC 10-04-03
Law Implemented: NDCC 10-04-15

TITLE 74

Seed Commission

DECEMBER 1997

CHAPTER 74-02-01

74-02-01-01. Seed testing fees - Sample size ~~--Free-seed-tests.~~ The definition of terms used in this section shall be the same as those defined in North Dakota Century Code section 4-09-01.

~~The--free--seed--tests--provided--for-in-North-Dakota-Century-Code section-4-09-08-shall-apply-only--to--seed--samples--of--cereals,--flax, sunflower,--alfalfa,-soybean,-and-edible-bean-seed-received-at-the-state seed-department-from-July-first-through--October--thirty-first--of--each year.~~

The following schedule of fees shall apply to tests on all samples of seed ~~which-are-not-eligible-for-free-tests~~ subject to change by the seed commission. All fees must accompany samples unless previous credit arrangements have been made.

	Germination Test		Seed Purity Test	
Alfalfa	$ ~~6.00~~	7.00	$ ~~8.00~~	10.00
Bluegrass	~~8.00~~	10.00	~~11.00~~	13.00
Bromegrass	~~8.00~~	10.00	~~11.00~~	13.00
Buckwheat	6.00		6.00	
Cereals	~~6.00~~	7.00	~~6.00~~	8.00
Clovers	~~6.00~~	7.00	~~8.00~~	10.00
Corn	~~6.50~~	7.00	~~6.00~~	8.00
Edible beans	~~6.50~~	7.00	~~6.00~~	8.00
Fescues	~~8.00~~	10.00	~~11.00~~	13.00
Flax	~~6.00~~	7.00	8.00	
Green needlegrass	25.00		~~11.00~~	13.00
Indiangrass	~~11.00~~	15.00	~~21.00~~	25.00

Creeping foxtail	~~9.00~~	10.00	~~21.00~~	25.00
Millet	~~6.00~~	7.00	~~6.00~~	10.00
Mustard and rape	~~6.00~~	7.00	~~8.00~~	10.00
Orchardgrass	~~8.00~~	10.00	~~11.00~~	13.00
Peas (field)	~~6.50~~	7.00	~~6.00~~	8.00
Reed canarygrass	~~8.00~~	10.00	~~11.00~~	13.00
Ryegrass	~~8.00~~	10.00	~~11.00~~	13.00
Sideoats grama	~~11.00~~	15.00	~~11.00~~	15.00
Sorghum	~~6.00~~	7.00	~~6.00~~	8.00
Soybeans	~~6.50~~	7.00	~~6.00~~	8.00
Sudangrass	~~6.00~~	7.00	~~6.00~~	8.00
Sunflowers	~~6.50~~	7.00	~~6.00~~	8.00
Switchgrass	~~11.00~~	15.00	~~11.00~~	13.00
Timothy	~~8.00~~	10.00	~~8.00~~	13.00
Trefoil	~~6.00~~	7.00	~~8.00~~	10.00
Western wheatgrass	~~11.00~~	15.00	~~11.00~~	15.00
Other wheatgrasses	~~8.00~~	10.00	~~11.00~~	13.00
Trees and shrubs	11.00		6.00	
Rape or canola		7.00		13.00

Charge For Tests on Kinds of Seed Not Listed:

~~The fees for testing kinds of seeds not listed will be comparable to those listed for a similar kind of seed~~ Fees for tests not listed will be established by the seed commission.

"Rush" service: ~~$5.00 per sample~~ 10.00 per test.

Samples which require excessive time - screenings, low-grade, dirty, or unusually difficult sample - ~~$10.00~~ 20.00 per hour.

Mixtures:

Mixtures of two or more kinds of seeds shall carry a fee equal to the fees for testing each component in the mixture.

Examinations:

For noxious weeds - ~~$4.00~~ 6.00.

150 gram noxious - ~~$5.00~~ 6.00.

Copper sulfate, ammonia for sweet clover - ~~$2.50~~ 20.00.

Weed check: identify weeds present in sample; preconditioning test (not for labeling) - ~~$3.00~~ 5.00.

Size of sample:

The minimum weights of samples submitted for tests shall be as follows:

1. Seed purity tests:

a. ~~Two~~ Four ounces [~~56.70~~ 113.4 grams] of grass seed, white or alsike clover, or seeds of similar size.

b. ~~Five~~ Eight ounces [~~141.75~~ 226.8 grams] of sweet clover, red clover, alfalfa, grasses, millet, rape, flaxseed, or seeds of similar size.

c. One ~~pound~~ and one-half pounds [~~453.59~~ 680.38 grams] of cereals, soybeans, or seeds of similar size.

2. Germination tests:

The minimum size of samples for a germination test shall be at least eight hundred seeds for testing (send one cup of seed to ensure best results).

Special tests:

Embryo test:	To determine loose smut in barley -	~~$12.00~~ 18.00
Tetrazolium test:	To give a quick estimate of potential seed viability - (not for labeling)	
	Cereals	$ 9.00
	Other Seeds	~~$15.00~~ 20.00
Seed Count:	Must have a purity test done at the same time	
	Soybeans	~~$ 1.00~~ 2.00
	Wheat, Durum, Barley	$ 2.00
Purity Analysis on a Treated Sample:	additional	$ 2.00

History: Amended effective September 1, 1981; May 1, 1988; December 18, 1989; December 1, 1997.
General Authority: NDCC 4-09-03, 4-09-08
Law Implemented: NDCC 4-09-08

74-02-01-07. Rules for affidavit of analysis for bagged agricultural seed. Application must be made to the state seed commissioner, or the commissioner's agent, for approval to use an affidavit of analysis for bagged agricultural seed lots labeled within the state of North Dakota.

1. Applications accepted for consideration:

a. Lots greater than one hundred containers distributed from one location.

b. Lots greater than two hundred fifty containers distributed from multiple locations.

2. Applications must include the following:

a. Name of applicant or labeler.

b. Kind or kind and variety of seed applied for.

c. Lot number of seed.

d. Amount of seed represented by application.

e. Number and weight of containers.

3. Seed that is transferred to a seller different than the labeler.

   a. The labeler shall provide a transfer certificate to the buyer, the North Dakota state seed department, and retain a copy stating to whom the seed was sold or transferred, seed lot number, amount of seed transferred, date of transfer, and serial numbers of copies of affidavit provided.

   b. The labeler shall provide a sufficient number of copies of the affidavit of analysis to the buyer or transferee for redistribution to the consumer.

   c. Seed cannot be transferred more than one time.

4. Application for use of affidavit of analysis for carryover seed that is currently tagged with individual tags will be considered providing that the seed lot be labeled by a North Dakota company or resident and all other criteria are met. Outdated tags must be removed when affidavit of analysis is approved on carryover lots.

5. Other pertinent information regarding seed lot under consideration.

6. When applicable, appropriate fees will be established by the state seed commission.

History: Effective December 1, 1997.
General Authority: NDCC 4-09-03, 4-09-08
Law Implemented: NDCC 4-09-08

TITLE 75

Department of Human Services

NOVEMBER 1997

CHAPTER 75-02-01.1

AGENCY SYNOPSIS: North Dakota Administrative Code Section 75-02-01.1-43, Lump Sums Received by a Member of Assistance Unit, ends the practice of considering nonrecurring lump sum income as income in determining Aid to Families With Dependent Children benefit amounts.

75-02-01.1-01. Definitions. For the purposes of this chapter:

1. "Aid to families with dependent children" means a program administered under North Dakota Century Code chapter 50-09 and title IV-A of the Social Security Act [42 U.S.C. 601 et seq.].

2. "Applicant" means an individual who is seeking a benefit under this chapter.

3. "Asset" means any kind of property or property interest, whether real, personal, or mixed, whether liquid or illiquid, and whether or not presently vested with possessory rights.

4. "Assistance unit" means an individual or group of related individuals within a household whose needs are recognized in a grant of benefits through aid to families with dependent children, including the parents of any dependent child and all brothers and sisters of any dependent child, whether by whole blood, half-blood, or adoption, but not including:

   a. Any child, parent of an eligible dependent child, or other caretaker relative who:

      (1) Receives supplemental security income benefits;

(2) Is an alien who does not meet citizen and alienage requirements;

(3) Is an alien and is ineligible for aid to families with dependent children benefits because of the application of sponsor-to-alien deeming;

(4) Is ineligible for aid to families with dependent children benefits as the result of the imposition of a sanction; or

(5) Was eligible for aid to families with dependent children benefits, but who became ineligible due to the receipt of lump sum income, provided that at least one dependent child, not ineligible due to the receipt of lump sum income, remains in the household.

b. Roomers and boarders; or

c. Household members who are not legal dependents of a member of the assistance unit.

5. "Base month" means the month, immediately before the processing month, about which the income and circumstances of the assistance unit are evaluated to determine the amount of any aid to families with dependent children to be paid during the benefit month.

6. "Benefit month" means the calendar month immediately following the processing month.

7. "Bona fide funeral arrangement" means a written agreement between a member of the assistance unit and a funeral service practitioner, licensed funeral establishment, or cemetery association whereby the contractor promises to provide burial services or merchandise to a member of the assistance unit in exchange for funds paid by a member of the assistance unit, but does not mean any contract of insurance.

8. "Burial plot" means a conventional gravesite, mausoleum, or any other repository customarily and traditionally used for the bodily remains of a deceased individual.

9. "Caretaker relative" means the relative so designated by the assistance unit who:

a. Lives with an eligible dependent child;

b. Is a pregnant woman, caretaker relative to no dependent child, in the last trimester of her pregnancy; or

c. Lives with a dependent child, under age eighteen and receiving supplemental security income benefits, who is the last child in the home.

10. "Child support agency" means any entity created by a county agency or any combination of county agencies, in execution of the county agency's duties under subsection 5 of North Dakota Century Code section 50-09-03.

11. "County agency" means the county social service board.

12. "Department" means the North Dakota department of human services.

13. "Dependent child" means a needy child:

    a. Who lives in the home of a relative by birth, marriage, or adoption;

    b. Who has been deprived of parental support or care by reason of:

        (1) The continued absence of a parent from the home, other than absence occasioned solely by reason of the performance of active duty in the uniformed services of the United States;

        (2) The death of a parent; or

        (3) ~~The--unemployment--of-the-parent-who-is-the-principal wage-earner;-or~~

        ~~(4)~~ The physical or mental incapacity of a parent; and

    c. Who is:

        (1) Under the age of eighteen; or

        (2) Under the age of nineteen and a full-time student in a secondary school or the equivalent (secondary school) level in a vocational school, or technical school, if, before the end of the calendar month in which the student attains age nineteen, the student may reasonably be expected to complete the program of such school.

14. "Earned income" means income currently received as wages, salaries, commissions, or profits from activities in which an individual or family is engaged through either employment or self-employment. There must be an appreciable amount of personal involvement and effort, on the part of the individual or family, for income to be considered "earned".

15. "Eligible caretaker relative" means a caretaker relative who:

    a. If, related to an eligible dependent child as a brother or sister, is not under sixteen years of age;

    b. If deprivation of parental support or care is by reason of the ~~unemployment of the parent who is the principal wage earner or~~ incapacity of a parent, is the ~~unemployed or~~ incapacitated parent or the eligible dependent child's other parent (but not stepparent);

    c. If deprivation of parental support or care is by reason of the death or continued absence of a parent, is the eligible dependent child's other parent (but not stepparent);

    d. Is not a recipient of supplemental security income benefits; and

    e. Is in financial need; or

    f. Is a pregnant woman, caretaker relative to no other dependent child, who or whose husband is incapacitated.

16. "Family" includes an individual or group of related individuals within a household whose needs are recognized in a grant of benefits through aid to families with dependent children, the parents of any dependent child and all brothers and sisters of any dependent child, whether by whole blood, half-blood, or adoption, any child, parent of an eligible dependent child, or other caretaker relative who receives supplemental security income benefits. Family includes an alien who does not meet citizen and alienage requirements, an alien who is ineligible for aid to families with dependent children benefits because of the application of sponsor-to-alien deeming, an individual who is ineligible for aid to families with dependent children benefits as the result of the imposition of a sanction, an individual who was eligible for aid to families with dependent children benefits, but who became ineligible due to the receipt of lump sum income, or an individual who is a household member who is a legal dependent of a member of the assistance unit, but does not include roomers and boarders.

17. "Full calendar month" means the period that begins at midnight on the last day of the previous month and ends at midnight on the last day of the month under consideration.

18. "Full-time student" means a student who:

    a. If in a secondary school, is enrolled in classes which, if completed, will earn the student four or more units of credit;

b. If in a vocational or technical school under state operation, a college, or a university, is enrolled in classes which, if completed, will earn the student twelve or more semester hours of credit during a regular term or six or more semester hours of credit during a summer term at an educational facility operating on a semester system, or twelve or more quarter hours of credit at an educational facility operating on a quarter system; or

c. If in a private vocational or technical school, is enrolled in classes which, according to a written statement from school officials, constitutes full-time enrollment.

19. "Ineligible caretaker relative" means a caretaker relative who is not an eligible caretaker relative.

20. "Living in the home of a relative" means a circumstance that arises when a relative assumes and continues responsibility for the day-to-day care and control of a child in a place of residence maintained by the relative (whether one or more) as the relative's own home. It includes situations in which the child or the relative requires medical treatment that requires a special living arrangement. It also includes situations, provided that the child is not absent from the home for a full calendar month, when the child:

a. Physically resides in the home, but is under the jurisdiction of a court and is receiving probation services or protective supervision;

b. Receives education while in an educational boarding arrangement in another community, including the Anne Carlsen school-hospital, if needed specialized services or facilities are unavailable in the home community or if transportation problems make school attendance near home difficult or impossible;

c. Receives physical or speech therapy at Camp Grassick during the summer months;

d. Receives special education at the school for the deaf or school for the blind, whether as a day student or a boarding student, except that a boarding student's needs are limited to those maintenance items that are not provided by the school; or

e. Receives education at a federal boarding school in another community, provided that the child was not placed in that setting following removal from the child's home by court order following a determination that the child was abused, neglected, or deprived, except that the child is entitled to a clothing and personal needs allowance only if that

allowance is made available for the child's use on a regular basis.

21. "Make an assistance payment" means, in the context of two-month retrospective budgeting, an activity that occurs on the date the department deposits an assistance payment check in the United States mail.

22. "Monthly income" means income from any source, either earned or unearned, which is computed and reduced to monthly units for the purpose of determining eligibility and benefits. Income may be received weekly, monthly, intermittently, or annually, but is computed and considered monthly.

23. "Needy" means:

    a. An assistance unit, otherwise eligible under this chapter, whose countable income, less any applicable disregards, is less than the income identified in the basic requirements table for a family of the size and composition of the assistance unit;

    b. An unwed parent or pregnant woman, resident of the Oppen Home, with an income of less than forty-five dollars per month; or

    c. A child resident of a boarding school with an income of less than forty-five dollars per month.

24. "Nonlegally responsible relative" means a relative who is not the child's parent.

25. "Parent" means the child's mother or father, whether by birth or adoption, but does not mean:

    a. An individual whose parental rights have been terminated with respect to that child; or

    b. A stepparent.

26. "Part-time student" means an individual enrolled in a secondary school, vocational school, technical school, college, or university who is not a full-time student.

27. ~~"Principal--wage--earner"--means--the--parent--in-a-two-parent household-who-earned-the-greater--amount--of--verified--income over--the--twenty-four-month--period-immediately-preceding-the month-when-application-was-made-for-benefits-under-the-aid--to families---with--dependent--children--program--for--unemployed parents;-or,-if-both-parents-have-earned-identical-amounts--of income--or--no--income--in--that-twenty-four-month-period,-the parent-so-designated-by-the-county-agency.~~

~~28.~~ "Processing month" means the month, immediately after the base month, and immediately before the benefit month, in which the county agency determines eligibility for, and the amount of, any aid to families with dependent children to be paid during the benefit month.

~~29.~~ 28. "Prospective budgeting" means:

a. The determination, made only with respect to the initial month of eligibility and the month immediately after the initial month of eligibility, based on the county agency's best estimate of the income and circumstances of the assistance unit in those months, of the amount of any grant of assistance in two months; and

b. The determination, made in all months, based on the county agency's best estimate of the income and circumstances of the assistance unit, of whether the income and circumstances anticipated for the benefit month, and the month immediately following the benefit month, will cause the assistance unit to be eligible in those two months.

~~30.~~ 29. "Recipient" means an individual who receives a benefit under this chapter.

~~31.~~ 30. "Regulation", as used in 45 CFR 205.10(a)(4)(i)(B) and (a)(15), includes any written statement of federal or state law or policy, including federal and state constitutions, statutes, regulations, rules, policy manuals or directives, policy letters or instructions, and relevant controlling decisions of federal or state courts.

~~32.~~ 31. "Relative by birth, marriage, or adoption" means an individual related to the dependent child by birth, whether by blood or half-blood, by marriage including a marriage that has been terminated by death or divorce, or by adoption, as father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, or first cousin.

~~33.~~ 32. "Retrospective budgeting" means a determination, made by the county agency during the processing month, based on income and circumstances of the assistance unit, during the base month, of the amount of any grant of assistance in the benefit month.

~~34.~~ 33. "Standard employment expense allowance" means the amount required by federal law to be first disregarded from the earned income of any child, relative applying for benefits under this chapter, or other individual whose needs are taken into account in determining eligibility under this chapter, but whose earned income is not required to be wholly disregarded as the income of a child who is a full-time

student or a part-time student who is not a full-time employee.

~~35.~~ 34. "Stepparent" means a person, ceremonially married to a parent of a child, but who is not also a parent of that child by either birth or adoption.

~~36.~~ 35. "Supplemental security income" means a program administered under title XVI of the Social Security Act [42 U.S.C. 1381 et seq.].

~~37.~~ 36. "The Act" means the Social Security Act [42 U.S.C. 301 et seq.].

~~38.~~ 37. "Title II" means title II of the Social Security Act [42 U.S.C. 401 et seq.].

~~39.~~ 38. "Title IV-A" means title IV-A of the Social Security Act [42 U.S.C. 610 et seq.].

~~40.~~ 39. "Title IV-D" means title IV-D of the Social Security Act [42 U.S.C. 651 et seq.].

~~41.~~ 40. "Unearned income" means income which is not earned income.

History: Effective March 1, 1995; amended effective July 1, 1997.
General Authority: NDCC 50-06-16, 50-09-25
Law Implemented: NDCC 50-06-05.1, 50-09

75-02-01.1-11. Deprivation of parental support or care. A dependent child must be shown to be both "deprived of parental support or care" and "needy", although a causal relationship between the two need not exist. The phrase encompasses the situation of any child who is in need and otherwise eligible, and whose parent has died, is continually absent from the home, or is physically or mentally incapacitated~~,--or--is--designated--as--principal--wage--earner--and--is unemployed~~. The requirement applies whether the parent was the chief breadwinner or devoted himself or herself primarily to the care of the child and whether or not the parents were married to each other. The determination that a child has been deprived of parental support or care is made in relation to the child's natural or adoptive parents.

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Law Implemented: NDCC 50-06-05.1, 50-09

75-02-01.1-13. Unemployment of the principal wage earner - Pay after performance.

~~1.--For-purposes-of-this-section:~~

a.--"Paid--employment"-means-employment-for-which-the-employee is-paid,-at-or-above-the-federal-minimum-hourly--wage,--at least--once--each--calendar--month,-in-lawful-money-of-the United-States-or-with-checks-drawn-on-banks-convenient--to the-place-of-employment.

b.--"Unemployed--parent"--means--a--principal--wage-earner-who meets-the-requirements-of-paragraphs-1-through-7.

(1)--A--principal--wage--earner-must-verify-that-he-or-she was-employed-less-than-one-hundred--hours,--including hours--when--holiday-pay-or-sick-pay-was-received,-in any-month-necessary-to-determine-benefits-under--this section.

(2)--A-principal-wage-earner-who-is-not-self-employed-must provide-an-employer's-statement-of-any--hours--worked by-the-principal-wage-earner.

(3)--A-principal-wage-earner-who-is-self-employed-must:

(a)--Provide,--as--verification,--a--reliable-written statement-made-by-a--disinterested--third--party who--is--not--an--employee-of-the-principal-wage earner--or--a--member--of--the--principal---wage earner's-family;

(b)--Verify---that--one-twelfth--of--the--annual--net profit,-as-reported-on-the-most--recent--federal income--tax--return--filed-by-the-principal-wage earner,--when--divided--by--the--federal--hourly minimum-wage,-produces-a-result-of-less-than-one hundred;-or

(c)--Verify---that--1.08--times--the--principal--wage earner's-net--income--from--self-employment,--as calculated--under--section--75-02-01.1-41,--when divided-by--the--federal--hourly--minimum--wage, produces-a-result-of-less-than-one-hundred.

(4)--A-principal-wage-earner-who-is-a-seasonal-worker-must verify-that-employment-of-less-than-one-hundred-hours in-a-relevant-month-was-not-due-to-weather-conditions when-the-principal-wage-earner-would--otherwise--have had-work-available.

(5)--A---principal---wage--earner--must--verify--that--the principal-wage-earner-is-not-unemployed-by-reason--of conduct--or-circumstances-that-result-or-would-result in-disqualification-for-unemployment-compensation.

(6)--Upon-application,-a-principal-wage-earner-must-report the-actual-number-of-hours--worked--in--the--calendar

month--immediately-preceding-the-month-of-application and-must-estimate-the-number-of-hours--the--principal wage---earner---expects--to--work--in--the--month--of application.

(7)--Once---determined--eligible--under--this--section,--a principal-wage-earner-must,-on-or--before--the--fifth working--day--of-each-month,-report-the-actual-number of-hours-worked-in--the--calendar--month--immediately preceding--the--month-the-report-is-made,-must-verify the-hours-worked,-and-must--estimate--the--number--of hours--the--principal--wage-earner-expects-to-work-in the-month-immediately-following-the-month-the--report is-made.

c.--"Work",--except-as-the-term-is-used-in-subsection-5,-means on-the-job--training,--work--supplementation,--alternative work---experience,--community--work--experience,--or--paid employment-or-any-combination-of-those-activities.

2.--Benefits--under-this-section-are-furnished-on-a-calendar-month basis.

3.--Unemployed--parent--benefits--under--the--aid-to-families-with dependent-children-program-are-available-only-if--all--aspects of--eligibility--required--under-this-chapter-are-established. Deprivation-may-be-established-for-unemployed-parent--benefits by-a-showing,-in-the-manner-required-by-this-section,-that-the principal--wage--earner--is---unemployed.----Eligibility---for unemployed----parent----benefits----depends---upon---continued unemployment.--Unemployed-parent-benefits-are-provided-with--a goal--of--encouraging--families--to--become-self-supporting-as rapidly-as-possible.

4.--Unemployed--parent-benefits-are-available-only-if-both-parents are-living-in-the-household.--The-parents-are-not-required--to be--married--to--each--other,--but--at--least-one-child-in-the household-must-be-the-child-of-both-parents.--The-parentage-of that--child--must--be-adjudicated,-established-by-marriage,-or acknowledged-by-the-father.

5.--The--principal--wage--earner--must-have-had-a-prior-connection with-the-labor-force-verified-under-either-subdivision-a-or-b.

a.--Within-a-one-year-period-prior-to-the-date-of-eligibility, the-principal-wage--earner--must--have--received--or--been qualified-for-job-insurance-benefits-under-the-laws-of-the state-or-of-the--United--States.---For--purposes--of--this subdivision,---railroad---unemployment--benefits--are--job insurance-benefits.--A-principal-wage-earner-is-treated-as qualified-for-job-insurance-benefits-if-the-principal-wage earner-would-have-been-eligible-to-receive--benefits--upon application-or-if-the-principal-wage-earner-performed-work

which,-had-it--been--covered,--would,--together--with--any covered-work,-have-made-the-principal-wage-earner-eligible for-job-insurance-benefits.--To-determine-if--a--principal wage--earner-was-qualified-for-job-insurance-benefits,-for purposes-of-this-subdivision,-the-total-amount-of-earnings during--the--base--period--must--be-established.--The-base period-is--the--first--four--quarters--in--the--last--five completed--quarters--prior--to-the-quarter-of-application. The-principal-wage-earner-must-have--had--earnings--in--at least--two--quarters-in-the-base-period;-total-base-period earnings-must-be-at--least--one--and--one-half--times--the highest--quarter--earnings--in--the--base-period;-and-base period-earnings--must--be--at--least--two--thousand--seven hundred-ninety-five-dollars.

b.--The--principal--wage--earner--must--have--had--six-or-more quarters-of-work--within--any--thirteen--calendar--quarter period--ending--within--one--year--prior-to-the-quarter-of application-for-benefits.--A-"quarter--of--work"--means--a period--of--three-consecutive-calendar-months-ending-March thirty-first,--June--thirtieth,--September--thirtieth,--or December--thirty-first-in-which-the-principal-wage-earner:

(1)--Received---earned--income--of--not--less--than--fifty dollars,-including-work-study-income;

(2)--Participated--in-a-community-work-experience-program, work-incentive--program,--or--job--opportunities--and basic---skills---program,---but--not--a--tribal--work experience-program;-or

(3)--Attended,---full---time,---an--elementary--school,--a secondary-school,-or-a-vocational-or-training--course designed---to--prepare--the--individual--for--gainful employment,-or--participated--in--an--educational--or training--program--under-the-Job-Training-Partnership Act-of-1982,-provided-that-no-more-than-four-quarters of--activity-under-this-paragraph-may-be-treated-as-a quarter-of-work.

6.--The--principal--wage--earner,--once--designated,--remains--the principal-wage-earner-for-each-month--the--household--receives benefits-under-the-program-for-unemployed-parents,-or-has-such benefits--suspended,--or--does--not--receive--benefits--solely because--it--has-already-received-benefits-for-six-months-in-a twelve-month-period.--If-the-case-is-closed-and-the--household is-without-such-benefits-for-at-least-one-full-calendar-month, a-new-application-must-be-made-and-a-new--designation--of--the principal-wage-earner-is-required.

7.--In--determining-which-parent-is-the-principal-wage-earner,-the county-agency-shall:

a.--Consider-the-verified-earnings-of-each-parent;

b.--Use--the--best--information--available--to--designate--the principal-wage-earner-if-reliable-verification-of-earnings cannot-be-secured;-and

c.--Designate-the-principal-wage-earner-if-both-parents-earned identical-amounts-of-income-or-earned-no-income.

8.--If-the-principal-wage-earner-was-employed-one-hundred-hours-or more-in-the-calendar-month-immediately-preceding-the-month--of application,---there---is--no--eligibility--in--the--month--of application.

9.--If--the--principal--wage--earner--was--employed--less-than-one hundred-hours-in-the-calendar-month-immediately-preceding--the month-of-application,-estimates-that-the-principal-wage-earner expects-to-work-less-than-one-hundred-hours-in--the--month--of application,--and-all-other-conditions-of-eligibility-are-met, eligibility-may-begin-as-early-as-the-date-of-application.

10.--If-the-principal-wage-earner-was-employed-one-hundred-hours-or more--in--the--month--immediately--preceding--the---month---of application,--is--employed--less-than-one-hundred-hours-in-the month-of-application,-estimates-that-the-principal-wage-earner expects--to--work--less--than--one--hundred-hours-in-the-month immediately-following-the-month-of-application,-and-all--other conditions--of--eligibility--are-met,-eligibility-may-begin-as early-as-the-first-day-of-the-month-immediately-following--the month-of-application.

11.--Once--determined--eligible--under-this-section,-if-a-principal wage-earner-reports-working-one-hundred-hours-or-more--in--the month--immediately-preceding-the-month-the-report-is-make,-and estimates-the--principal--wage--earner--expects--to--work--one hundred--hours--or-more-in-the-month-immediately-following-the month-the-report-is-made,-eligibility-under-this-section--ends at-the-end-of-the-month-the-report-is-made.

12.--Eligibility--for-unemployed-parent-benefits-may-be-established for-no-more-than-six-months-in-any-twelve-month--period.---The six--months--of-potential-eligibility-need-not-be-consecutive. For-purposes-of-applying-this-limitation,-a-month-is-a-benefit month-if:

a.--Eligibility-is-established-at-any-time-during-that-month;

b.--The--household--actually-receives-benefits-even-though-the family-is-totally-ineligible;

c.--The--household--is--eligible-for-benefits-of-less-than-ten dollars;-or

d.--The household is eligible but receives benefits in excess of those for which it was eligible.

13.--a.--Neither parent may, without good cause, refuse a bona fide offer of employment or training for employment in the calendar month immediately preceding authorization of benefits under this chapter.

b.--If an offer of employment or training was made through job service North Dakota, job service North Dakota shall determine if a bona fide offer was made and if there was good cause for refusing it.

c.--If an offer of employment or training was made other than through job service North Dakota, the county agency shall determine if a bona fide offer was made and if there was good cause for refusing it, considering the following factors:

(1)--Whether there was a definite offer of employment at wages meeting any applicable minimum wage requirements and that are customary for such work in the community;

(2)--Whether there were any questions as to the physical or mental ability of the principal wage earner to engage in the offered employment;

(3)--Whether there were any questions of the working conditions such as risks to health, safety, or lack of workers' compensation protection;

(4)--Whether the parent had a way to get to or from the particular job, including evidence the parent reasonably attempted to arrange for transportation;

(5)--Whether, as a condition of being employed, the parent would be required to join a company union, or to resign or refrain from any bona fide labor organization, or would be denied the right to retain membership in and observe the lawful rules of any such organization;

(6)--Whether the position offered is vacant directly due to a strike, lockout, or other labor dispute;

(7)--Whether the work is at an unreasonable distance from the parent's residence, provided one way travel time of one hour or less may not be treated as an unreasonable distance; and

(8)--Whether the rate of pay, hours, or other conditions of the work offered are substantially less favorable

to the parent than those prevailing for similar work in the locality.

d. If it is determined that a bona fide offer of employment or training was refused by a parent without good cause:

(1) In the case of a recipient assistance unit, the entire unit is ineligible for the calendar month beginning after the month in which the determination was made; and

(2) In the case of an applicant assistance unit, the entire unit is ineligible for the calendar month of application and the following month.

14. Each parent must accept any unemployment compensation benefits to which the parent is entitled. Each parent must provide verification, from job service North Dakota, as to whether the parent is qualified for unemployment compensation benefits; and, if qualified, must make application for unemployment compensation benefits. If a parent who qualifies for unemployment compensation benefits fails to apply for those benefits, the needs of that parent must be deleted from the amount of benefits otherwise provided to the assistance unit under this chapter.

15. No assistance unit may be found eligible under this section unless, within seven working days after the county agency initiates a referral to the job opportunities and basic skills program, both parent members of that unit:

a. Verify a current application for employment is on file at an office of job service North Dakota;

b. Verify application for any unemployment benefits that may be due either parent;

c. Sign and return to the county agency a statement acknowledging the parent's duties and responsibilities; and

d. Verify beginning and continuing a job search satisfactory to that parent's job opportunities and basic skills program coordinator.

16. a. Except as provided in subdivision b, both parents in a recipient assistance unit must comply with this subsection.

(1) A parent engaged in paid employment at least thirty-two hours per week need not engage in job search or unpaid work.

(2) A parent engaged in paid employment of at least twenty-four hours per week but less than thirty-two hours per week must engage in at least eight hours of job search per week.

(3) A parent engaged in paid employment of less than twenty-four hours per week must engage in at least eight hours of job search per week, at least eight hours of unpaid work per week, and a total of at least forty hours per week of a combination of paid employment, job search, and unpaid work.

(4) A parent not engaged in paid employment must engage in at least eight hours of job search per week and at least thirty-two hours of unpaid work per week.

(5) A parent under age twenty-five who has neither completed high school nor earned a general equivalency diploma, and who is making satisfactory progress in either of those educational activities, may substitute that progress for up to thirty-two hours of unpaid work per week, but must engage in at least eight hours of job search per week.

b. If one parent complies fully with subdivision a, the second parent shall engage in unpaid work, job search, and educational activities only at times necessary child care is made available at the expense of the department and is not required to engage in those activities for more than twenty hours per week.

17. a. No benefits under this section may be provided for the calendar month of application until the assistance unit complies with subsection 15.

b. No benefits under this section may be provided for the calendar month immediately after the month of application unless:

(1) Benefits are provided in the month of application;

(2) The assistance unit continues the job search; and

(3) For any period, beginning seven calendar days after the day notice of approval is issued and ending on the nineteenth day of that month, the assistance unit complies with subsection 16.

c. No benefits under this section may be provided for the third and subsequent calendar months after the month of application unless:

(1)--Benefits--were--provided--in-the-month-of-application and-the-month--immediately--following--the--month--of application;-and

(2)--For--a--period,-beginning-on-the-twentieth-day-of-the month-two-months-before-the-benefit-month-and--ending on-the-nineteenth-day-of-the-month-before-the-benefit month,---the---assistance----unit----complies----with subsection-16.

18.--A--parent--who-is-required-to-perform-an-activity-shall-verify either-the-performance-of-the-required-activity-or--good--cause for-failure-to-perform.

19.--Good-cause-for-failure-to-perform-the-required-activity-exists only-if-good-cause-would--exist--for--failure--or--refusal--to participate-in-the-job-opportunities-and-basic-skills-program, except:

a.--If--the--parent-is-too-ill-to-participate-or-refuses-major medical-care,-the-other--parent--in--the--household--shall perform;

b.--Good-cause-may-not-be-based-on-a-claim-that-the-designated work-program-assignment-does-not-meet-appropriate-work--or training-criteria;-and

c.--A--claim--of-good-cause-must-be-such-as-would-preclude-any reasonable---employee,----of----ordinary----ability----and responsibility,--from-working,-considering-the-totality-of circumstances,-and-particularly-considering-the-efforts-of the-parent-to-overcome-the-obstacle-to-participation.

20.--If--the--principal--wage--earner--fails--to-perform-activities required-under-this-section,-shows-good-cause-for-that-failure to--perform,--or-establishes-an-exemption-under-subdivisions-b through-k-of-subsection-1-of-section-75-02-01.1-70,-the-second parent--must--perform--the-required-activities,-subject-to-all provisions-of-this-section,-and-may-not--show--good--cause--or establish-an-exemption.

21.--A--household-is-entitled-to-adequate-notice-of-a-determination that-a-parent-failed-without-good-cause-to-perform--activities required--under--this--section.---The--notice--must-inform-the household-that-it-may--be--reinstated--if--an--appeal--of--the decision--described--in--the-notice-is-made-within-ten-days-of the-date-of-the-notice.

22.--Household--members--subject--to--this--section--who-are-native Americans-residing--in--the--service--area--of--a--tribal--job opportunities--and--basic-skills-program,-and-who-are,-or-upon application-would--be,--eligible--for--services--through--that program,--must-verify-participation-in-all-activities-required

~~under-this--section--that--are--made--available--through--that program.~~ Repealed effective July 1, 1997.

History: ~~Effective-March-1,-1995;-amended-effective-January-1,-1996.~~
General Authority: ~~NDCC-50-06-16,-50-09-25~~
Law Implemented: ~~NDCC-50-06-05.1,-50-09~~

75-02-01.1-17. Eligibility throughout month.

1. In the first month in which eligibility is established, based on any one application, the benefit amount is that pro rata portion of the monthly benefit amount equal to the percentage of the month remaining after the later of the first day of eligibility or the date of application, except:

   a. In the case of a family that has entered North Dakota from a state which issues grants twice a month, the benefit amount is that pro rata portion of the monthly benefit amount equal to the percentage of the month remaining after the later of the date coverage in the other state ends or the date of application;

   b. The benefit amount may be adjusted to correct an underpayment or overpayment arising out of previous periods of eligibility; and

   c. In the case of an assistance unit which includes members who were eligible for and receiving medicaid benefits at the time the unit requests aid to families with dependent children, if the assistance unit provides all necessary verification and a completed application within forty-five days or by the end of the month following the month of request, whichever is less, the benefit amount in the month of request is that pro rata portion of month remaining after the date of request.

2. In the second and subsequent months in which eligibility is established, based on any one application, if the monthly reporting requirements are met, ~~and,-where-applicable,-the requirements-of-section-75-02-01.1-13,--concerning--unemployed parent--cases--are-met,~~ the household continues to be eligible throughout the month if eligible for any portion of the month.

History: Effective October 1, 1995; amended effective July 1, 1997.
General Authority: NDCC 50-06-16, 50-09-25
Law Implemented: NDCC 50-06-05.1, 50-09

AGENCY SYNOPSIS: North Dakota Administrative Code Section 75-02-01.1-43, Lump Sums Received by a Member of Assistance Unit, ends the practice of considering nonrecurring lump sum income as income in determining Aid to Families With Dependent Children benefit amounts.

75-02-01.1-43. Lump sums received by a member of assistance unit.

1. When the assistance unit's income, after applying applicable disregards, exceeds the standard of need applicable to the unit because of receipt of nonrecurring earned or unearned lump sum income, to the extent that the income is not earmarked and used for the purpose for which it is paid, the assistance unit is ineligible for the full number of months derived by dividing the lump sum income and other income by the monthly need standard for an assistance unit of that size. Any income remaining from this calculation is income in the first month following the period of ineligibility. The period of ineligibility begins with the payment month corresponding to the month of receipt of the lump sum income.

2. For purposes of this section, "lump sum income" includes retroactive monthly benefits provided under title II and other retroactive monthly benefits, payments in the nature of windfall, such as lottery or gambling winnings or inheritances, judgments or settlements for injuries to person or property to the extent that the payment is not earmarked and used for the purpose for which it was paid such as payments on back medical bills resulting from injuries, funeral and burial costs, and repair or replacement of lost or damaged assets, and workers' compensation awards.

3. The period of ineligibility may be shortened when:

   a. The applicable standard of need changes and the amount of benefits the assistance unit would have received also changes;

   b. The lump sum income or a portion of the lump sum income becomes unavailable to the assistance unit for a reason beyond the control of any member of the family, such as loss or theft of the income, collection of income in settlement of a court-imposed judgment, or life threatening circumstances; or

   c. Members of the assistance unit incur and pay for medical expenses of a type which is a covered service under medicaid.

4. This section applies to the receipt of nonrecurring earned or unearned lump sum income received before April 25, 1997.

History: Effective March 1, 1995; amended effective May 1, 1997.
General Authority: NDCC 50-06-16, 50-09-25
Law Implemented: NDCC 50-06-05.1, 50-09

75-02-01.1-67. Job opportunities and basic skills program - Participation requirements in households receiving unemployed parent benefits.

~~1. Each nonexempt parent in a family receiving unemployed parent benefits shall participate or be available for participation in an approved work program component for a total of at least thirty-two hours per week.~~

~~2. An individual participating in a work experience program for at least thirty-two hours per week must be treated as a participant in the job opportunities and basic skills program.~~

~~3. If a participant receiving unemployed parent benefits is under age twenty-five and has not received a high school diploma or a general equivalency diploma, the employability plan must include high school attendance or general equivalency diploma program attendance in lieu of other participation requirements, if the participant is involved in education or training no less than twelve hours per week, and makes satisfactory progress.~~

~~4. If the principal wage earner is exempt, the second parent must meet the participation requirements for the family. If a nonexempt principal wage earner is sanctioned for failure to participate in the program, the second parent shall meet the participation requirements for the family. If the second parent fails to meet the participation requirements, the family is not eligible for aid to families with dependent children. The second parent is subject to all participation requirements of a principal wage earner, and may not show good cause for failure or refusal to participate.~~ Repealed effective July 1, 1997.

History: ~~Effective March 1, 1995.~~
General Authority: ~~NDCC 50-06-16, 50-09-25~~
Law Implemented: ~~NDCC 50-06-05.1, 50-09~~

75-02-01.1-70. Job opportunities and basic skills program - Exemptions from participation.

1. An individual is exempt from participation in the job opportunities and basic skills program if the individual is:

~~a.~~ 1. A native American who resides in the service area of a tribal job opportunities and basic skills program and meets the requirements of that program;

~~b.~~ 2. Suffering from a temporary illness or injury, verified by reliable medical evidence, which temporarily prevents entry into employment or training;

~~c.~~ 3. Age sixty or older;

~~d.~~ 4. Incapacitated with a physical or mental impairment, verified by reliable medical evidence, which, by itself or in conjunction with age, prevents entry into employment or training;

~~e.~~ 5. An individual whose substantially continuous presence in the household is necessary to care for another individual in the household, to whom the individual seeking exemption owes a legal duty to provide care, who has a condition, verified by reliable medical evidence, which does not permit self-care, care by another household member, or care provided as supportive services;

~~f.~~ 6. A dependent child, age fifteen or younger, who is not also a custodial parent;

~~g.~~ 7. A dependent child, age sixteen or older, who is not also a custodial parent, who is enrolled or accepted for enrollment as a full-time student for the next or current school term in an elementary school, secondary school, vocational school, or technical school;

~~h.~~ 8. Employed in unsubsidized employment for not less than an average of thirty hours per week, at a salary or wage equaling or exceeding the federal hourly minimum wage, at employment expected to last at least thirty days; and who, if self-employed, is earning a weekly gross income from self-employment equaling or exceeding thirty times the federal hourly minimum wage and a monthly net income from self-employment, as calculated under section 75-02-01.1-41, equaling or exceeding ninety-seven and one-half times the federal hourly minimum wage.

~~i.~~ 9. Pregnant, in the fourth or later month of a pregnancy, verified by a licensed physician, physician's assistant, nurse practitioner, or midwife, whose verification includes the estimated delivery date;

~~j.~~ 10. A parent who, if age nineteen or younger, has completed a high school education or its equivalent, or other eligible caretaker relative of a child under age three, or, effective January 1, 1996, under age two, who is personally caring for that child on a full-time basis; or

k. 11. A full-time volunteer serving in the volunteers in service to America program.

2. Exemptions described in subsection 1 apply to the recipients of aid to families with dependent children - unemployed parent benefits except neither parent may claim an exemption for personally caring for a child, under age three, on a full-time basis.

History: Effective March 1, 1995; amended effective July 1, 1997.
General Authority: NDCC 50-06-16, 50-09-25
Law Implemented: NDCC 50-06-05.1, 50-09

75-02-01.1-71. Job opportunities and basic skills program - Referral.

1. Any individual not exempt from the job opportunities and basic skills program and anyone who volunteers must be referred to the program. Referrals of applicants for unemployed parents who seek benefits under section 75-02-01.1-13 may be made at the time of application. Referrals of other individuals may be made only after the individual is determined eligible for aid to families with dependent children.

2. The referred individual shall contact the coordinator within seven days of the referral date to set up an appointment for program orientation, assessment, and employability planning.

3. Upon referral, the county agency may authorize supportive services, limited to child care and transportation allowance, solely for the first thirty days after the referral date and solely when necessary to allow the individual to complete the planning process.

History: Effective March 1, 1995; amended effective July 1, 1997.
General Authority: NDCC 50-06-16, 50-09-25
Law Implemented: NDCC 50-06-05.1, 50-09

75-02-01.1-82. Job opportunities and basic skills program - Alternate work experience.

1. Alternate work experience offers work, based on a forty-hour workweek, that includes work expectations found in unsubsidized employment, provided at private nonprofit or public worksites. Alternate work experience is provided for up to thirty-two hours per week in conjunction with structured job search activities the remaining eight hours per week.

2. A parent under age twenty-five who has neither completed high school nor earned a general equivalency diploma, and who is maintaining satisfactory progress in either of those

educational activities, may substitute that educational activity for alternate experience.

3. ~~If a family is eligible for aid to families with dependent children due to the unemployment of the parent who is the principal wage earner, each parent in that family must participate in alternate work experience for at least thirty-two hours per week.~~

4. Workers' compensation coverage must be provided to alternate work experience participants.

History: Effective March 1, 1995; amended effective July 1, 1997.
General Authority: NDCC 50-06-16, 50-09-25
Law Implemented: NDCC 50-06-05.1, 50-09

75-02-01.1-83. Job opportunities and basic skills program - On-the-job training. On-the-job training provides, through a negotiated agreement, payment to an employer for the costs of training and lower productivity normally associated with a new employee. The agreement is intended to place a participant in an occupational position that requires training. The training is intended to lead to permanent employment with that employer or one that is similar in its training requirements.

1. The agreement must be for a fixed price that does not exceed fifty percent of the average wage paid by the employer to the participant during the training period.

2. The starting wage of an on-the-job training participant must be at least equal to the federal minimum wage rate.

3. On-the-job training participants shall be compensated at the same rates, and receive the same benefits, as other individuals similarly employed by the employer.

4. Wages paid to an on-the-job training participant must be treated as earned income for purposes of this chapter.

5. If an on-the-job training participant becomes ineligible for aid to families with dependent children benefits because of earned income ~~or, in the case of benefits provided under section 75-02-01.1-13, because of employment for one hundred or more hours per month~~:

   a. That person shall remain a participant for the duration of the on-the-job training and may be eligible for those supportive services available to other similarly situated participants; and

   b. If that participant would have been eligible for transitional child care, under a program furnishing such

care pursuant to 45 CFR part 256, at the time the ineligibility for aid to families with dependent children benefits occurred, the participant may:

(1) Remain eligible for transitional child care, after the on-the-job training ends, for the number of months that remain in the twelve-month period following the month in which the participant became ineligible for aid to families with dependent children benefit; or

(2) Receive child care as a supportive service to a participant if the person otherwise meets the requirements to be a participant.

History: Effective March 1, 1995; amended effective July 1, 1997.
General Authority: NDCC 50-06-16, 50-09-25
Law Implemented: NDCC 50-06-05.1, 50-09

75-02-01.1-84. Job opportunities and basic skills program - Work supplementation program.

1. Public and private employers may receive payment for extraordinary costs of training intended to assist a recipient to obtain unsubsidized employment. The payment is diverted from, and limited to, a negotiated amount that cannot exceed the recipient's aid to families with dependent children grant. A work supplementation program participant must be considered a regular employee, and receive benefits and enjoy working conditions at the same level and to the same extent as other employees working a similar length of time and doing the same type of work.

2. Work supplementation program payments may be made only pursuant to a contract signed by the employer, the work supplementation program participant, and the coordinator.

3. The length of the contract is limited to the training time required for the recipient to learn the necessary job skills.

4. The initial work supplementation program contract may be up to six months in length. The contract may be extended, where necessary, provided that the total length of all work supplementation program contracts or extensions, entered into with respect to a particular recipient, may not exceed nine months.

5. If a work supplementation participant becomes ineligible for aid to families with dependent children benefits because of earned income ~~or, in the case of benefits provided under section 75-02-01.1-13, because of employment for one hundred or more hours per month~~:

a. That person shall remain a participant for the duration of the work supplementation contract and may be eligible for those supportive services available to other similarly situated participants; and

b. If that participant would have been eligible for transitional child care, under a program furnishing such care pursuant to 45 CFR part 256, at the time the ineligibility for aid to families with dependent children benefits occurred, the participant may:

(1) Remain eligible for transitional child care, after the work supplementation ends, for the number of months that remain in the twelve-month period following the month in which the participant became ineligible for aid to families with dependent children benefits; or

(2) Receive child care as a supportive service to a participant if the person otherwise meets the requirements to be a participant.

6. Workers' compensation coverage must be provided for work supplementation program participants.

History: Effective March 1, 1995; amended effective July 1, 1997.
General Authority: NDCC 50-06-16, 50-09-25
Law Implemented: NDCC 50-06-05.1, 50-09

JANUARY 1998

CHAPTER 75-02-06

AGENCY SYNOPSIS: Regarding Proposed Amendments to North Dakota Administrative Code Chapter 75-02-06, Ratesetting for Nursing Home Care

North Dakota Administrative Code Section 75-02-06-01(3) is amended to refine the definition of "adjustment factor".

North Dakota Administrative Code Section 75-02-06-03, Depreciation, is amended to repeal provisions authorizing recapture of depreciation, to identify the date of acquisition of depreciable property, and to clarify how the historical cost basis of an asset is to be determined.

North Dakota Administrative Code Section 75-02-06-10, Bad Debts, is amended to correct cross-references to Section 75-02-06-14.

North Dakota Administrative Code Section 75-02-06-12, Offsets to Cost, is amended to include a definition of Medicare Part B income for purposes of determining income offsets.

North Dakota Administrative Code Section 75-02-06-12.1, Nonallowable Costs, is amended to include, within the list of nonallowable costs, costs associated with acquiring licensed nursing facility capacity, good will, and certain lease costs.

North Dakota Administrative Code Section 75-02-06-14, Resident Days, is amended to include a statement concerning payment for hospital and therapeutic leave days following a Medicare benefit period.

North Dakota Administrative Code Section 75-02-06-16, Rate Determinations, is amended to eliminate outdated material, to provide for adjustment factors required by law, to provide a waiver to occupancy

limits as required by law, to provide a method for calculating a property rate for facilities changing ownership, having a capacity increase, or having significant renovations or replacements, and to provide a method for including disaster recovery costs in rates.

North Dakota Administrative Code Section 75-02-06-17(2) is amended to change the default classification, applied when a resident classification review is not completed, from Special Care B to reduced Physical Functioning C.

North Dakota Administrative Code Section 75-02-06-21, Specialized Rates for Extraordinary Medical Care, is amended to include a methodology for establishing specialized rates when the cost of care does not exceed certain limitations.

North Dakota Administrative Code Section 75-02-06-22(1) is amended to correct cross-references to Section 75-02-06-14.

North Administrative Code Section 75-02-06-26(1) is amended to specify information to be filed with a request for reconsideration of rates, and to specify the times within which requested additional documentation must be furnished.

75-02-06-01. Definitions. In this chapter, unless the context or subject matter requires otherwise:

1. "Accrual basis" means the recording of revenue in the period when it is earned, regardless of when it is collected, and the recording of expenses in the period when incurred, regardless of when they are paid.

2. "Actual rate" means the facility rate for each cost category calculated using allowable historical operating costs and adjustment factors.

3. "Adjustment ~~factors~~ factor" means ~~indices--used--to-adjust reported-costs-for-inflation-or-deflation-based--on--forecasts for--the--rate--year~~ the appropriate composite economic change index.

4. "Admission" means any time a resident is admitted to the facility from an outside location, including readmission resulting from a discharge.

5. "Allowable cost" means the facility's actual cost after appropriate adjustments as required by medical assistance regulations.

6. "Bona fide sale" means the purchase of a facility's capital assets with cash or debt in an arm's length transaction. It does not include:

   a. A purchase of shares in a corporation that owns, operates, or controls a facility except as provided under subsection 3 of section 75-02-06-07;

   b. A sale and leaseback to the same licensee;

   c. A transfer of an interest to a trust;

   d. Gifts or other transfers for nominal or no consideration;

   e. A merger of two or more related organizations;

   f. A change in the legal form of doing business;

   g. The addition or deletion of a partner, owner, or shareholder; or

   h. A sale, merger, reorganization, or any other transfer of interest between related organizations.

7. "Building" means the physical plant, including building components and building services equipment, licensed as a facility, and used directly for resident care, and auxiliary buildings including sheds, garages, and storage buildings located on the site used directly for resident care.

8. "Capital asset" means a facility's buildings, land improvements, fixed equipment, movable equipment, leasehold improvements, and all additions to or replacements of those assets used directly for resident care.

9. "Chain organization" means a group of two or more health care facilities owned, leased, or, through any other device, controlled by one business entity. This includes not only proprietary chains, but also chains operated by various religious and other charitable organizations. A chain organization may also include business organizations engaged in other activities not directly related to health care.

10. "Close relative" means an individual whose relationship by blood, marriage, or adoption to an individual who is directly or indirectly affiliated with, controls, or is controlled by a facility is within the third degree of kinship.

11. "Community contribution" means contributions to civic organizations and sponsorship of community activities. It does not include donations to charities.

12. "Cost category" means the classification or grouping of similar or related costs for purposes of reporting, the determination of cost limitations, and determination of rates.

13. "Cost center" means a division, department, or subdivision thereof, group of services or employees or both, or any unit or type of activity into which functions of a facility are divided for purposes of cost assignment and allocations.

14. "Cost report" means the department approved form for reporting costs, statistical data, and other relevant information of the facility.

15. "Department" means the department of human services.

16. "Depreciable asset" means a capital asset for which the cost must be capitalized for ratesetting purposes.

17. "Depreciation" means an allocation of the cost of an asset over its estimated useful life.

18. "Depreciation guidelines" means the American hospital association's guidelines as published by American Hospital Publishing, Inc., in "Estimated Useful Lives of Depreciable Hospital Assets", revised 1993 edition.

19. "Desk audit rate" means the rate established by the department based upon a review of the cost report submission prior to an audit of the cost report.

20. "Direct care costs" means the cost category for allowable nursing and therapy costs.

21. "Direct costing" means identification of actual costs directly to a facility or cost category without use of any means of allocation.

22. "Discharge" means the voluntary or involuntary release of a bed by a resident when the resident vacates the nursing facility premises.

23. "Employment benefits" means fringe benefits, other employee benefits including vision insurance, disability insurance, long-term care insurance, employee assistance programs, employee child care benefits, and payroll taxes.

24. "Established rate" means the rate paid for services.

25. "Facility" means a nursing facility not owned or administered by state government or a nursing facility, owned or administered by state government, which agrees to accept a rate established under this chapter. It does not mean an intermediate care facility for the mentally retarded.

26. "Fair market value" means value at which an asset could be sold in the open market in a transaction between informed, unrelated parties.

27. "Final decision rate" means the amount, if any, determined on a per day basis, by which a rate otherwise set under this chapter is increased as a result of a request for reconsideration, a request for an administrative appeal, or a request for judicial appeal taken from a decision on an administrative appeal.

28. "Final rate" means the rate established after any adjustments by the department, including adjustments resulting from cost report reviews and audits.

29. "Fixed equipment" means equipment used directly for resident care affixed to a building, not easily movable, and identified as such in the depreciation guidelines.

30. "Freestanding facility" means a nursing facility which does not share basic services with a hospital-based provider.

31. "Fringe benefits" means workers' compensation insurance, group health or dental insurance, group life insurance, retirement benefits or plans, uniform allowances, and medical services furnished at nursing facility expense.

32. "Highest market driven compensation" means the highest compensation given to an employee of a freestanding facility who is not an owner of the facility or is not a member of the governing board of the facility.

33. "Historical operating costs" means the allowable operating costs incurred by the facility during the report year immediately preceding the rate year for which the established rate becomes effective.

34. "Hospice general inpatient care" means short-term inpatient care necessary for pain control or acute or chronic symptom management that cannot feasibly be provided in other settings. It does not mean care provided to an individual residing in a nursing facility.

35. "Hospice inpatient respite care" means short-term inpatient care provided to an individual when necessary to relieve family members or other persons caring for the individual at home. Care may be provided for no more than five consecutive days. For purposes of the definition, home does not include nursing facility.

36. "Hospital leave day" means any day that a resident is not in the facility, but is in an acute care setting as an inpatient.

37. "Indirect care costs" means the cost category for allowable administration, plant, housekeeping, medical records, chaplain, pharmacy, and dietary, exclusive of food costs.

38. "In-house resident day" for nursing facilities means a day that a resident was actually residing in the facility and was not on therapeutic leave or in the hospital. "In-house resident day" for hospitals means an inpatient day.

39. "Institutional leave day" means any day that a resident is not in the facility, but is in another nursing facility, intermediate care facility for the mentally retarded, or basic care facility.

40. "Land improvements" means any improvement to the land surrounding the facility used directly for resident care and identified as such in the depreciation guidelines.

41. "Limit rate" means the rate established as the maximum allowable rate for a cost category.

42. "Lobbyist" means any person who in any manner, directly or indirectly, attempts to secure the passage, amendment, defeat, approval, or veto of any legislation, attempts to influence decisions made by the legislative council, and is required to register as a lobbyist.

43. "Medical assistance program" means the program which pays the cost of health care provided to eligible recipients pursuant to North Dakota Century Code chapter 50-24.1.

44. "Medical records costs" means costs associated with the determination that medical record standards are met and with the maintenance of records for individuals who have been discharged from the facility. It does not include maintenance of medical records for in-house residents.

45. "Movable equipment" means movable care and support services equipment generally used in a facility, including equipment identified as major movable equipment in the depreciation guidelines.

46. "Other direct care costs" means the cost category for allowable activities, social services, laundry, and food costs.

47. "Payroll taxes" means the employer's share of Federal Insurance Contributions Act (FICA) taxes, governmentally required retirement contributions, and state and federal unemployment compensation taxes.

48. "Pending decision rate" means the amount, determined on a per day basis, by which a rate otherwise set under this

chapter would increase if a facility prevails on a request for reconsideration, on a request for an administrative appeal, or on a request for a judicial appeal taken from a decision on an administrative appeal; however, the amount may not cause any component of the rate to exceed rate limits established under this chapter.

49. "Private-pay resident" means a nursing facility resident on whose behalf the facility is not receiving medical assistance payments and whose payment rate is not established by any governmental entity with ratesetting authority, including veterans' administration or medicare.

50. "Private room" means a room equipped for use by only one resident.

51. "Property costs" means the cost category for allowable real property costs and other costs which are passed through.

52. "Provider" means the organization or individual who has executed a provider agreement with the department.

53. "Rate year" means the calendar year from January first through December thirty-first.

54. "Reasonable resident-related cost" means the cost that must be incurred by an efficiently and economically operated facility to provide services in conformity with applicable state and federal laws, regulations, and quality and safety standards. Reasonable resident-related cost takes into account that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost-conscious buyer pays for a given item or services.

55. "Related organization" means a close relative or person or an organization which a provider is, to a significant extent, associated with, affiliated with, able to control, or controlled by, and which furnishes services, facilities, or supplies to the provider. Control exists where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the policies of an organization or provider.

56. "Report year" means the fiscal year from July first through June thirtieth of the year immediately preceding the rate year.

57. "Resident" means a person who has been admitted to the facility, but not discharged.

58. "Resident day" in a nursing facility means all days for which service is provided or for which payment is ordinarily sought, including hospital leave days and therapeutic leave days. The

day of admission and the day of death are resident days. The day of discharge is not a resident day. "Resident day" in a hospital means all inpatient days for which payment is ordinarily sought.

59. "Respite care" means short-term care provided to an individual when necessary to relieve family members or other persons caring for the individual at home.

60. "Routine hair care" means hair hygiene which includes grooming, shampooing, cutting, and setting.

61. "Significant capacity increase" means an increase of fifty percent or more in the number of licensed beds or an increase of twenty beds, whichever is greater; but does not mean an increase by a facility which reduces the number of its licensed beds and thereafter relicenses those beds, and does not mean an increase in a nursing facility's licensed capacity resulting from converting beds formerly licensed as basic care beds.

62. "Standardized resident day" means a resident day times the classification weight for the resident.

63. "Therapeutic leave day" means any day that a resident is not in the facility, another nursing facility, an intermediate care facility for the mentally retarded, a basic care facility, or an acute care setting, or, if not in an institutional setting, is not receiving home and community-based waivered services.

64. "Top management personnel" means owners, board members, corporate officers, general, regional, and district managers, administrators, and any other person performing functions ordinarily performed by such personnel.

65. "Working capital debt" means debt incurred to finance nursing facility operating costs, but does not include debt incurred to acquire or refinance a capital asset or to refund or refinance debt associated with acquiring a capital asset.

History: Effective September 1, 1980; amended effective December 1, 1983; June 1, 1985; September 1, 1987; January 1, 1990; January 1, 1992; November 22, 1993; January 1, 1996; July 1, 1996; January 1, 1998.
General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4; 42 USC 1396a(a)(13)

75-02-06-03. Depreciation.

1. Ratesetting principles require that payment for services includes depreciation on all capital assets used to provide necessary services. ~~This includes assets~~

a. Capital assets that may have been fully or partially depreciated on the books of the provider, but are in use at the time the provider enters the program, may be depreciated. The useful lives of such assets are considered not to have ended and depreciation calculated on the revised extended useful life is allowable. ~~Likewise,~~ a To properly provide for costs or the valuation of such assets, an appraisal is required if the provider has no historical cost records or has incomplete records of the capital assets.

b. A depreciation allowance is permitted on assets used in a normal standby or emergency capacity.

c. If any depreciated personal property asset is sold or disposed of for an amount different than its undepreciated value, the difference represents an incorrect allocation of the cost of the asset to the facility and must be included as a gain or loss on the cost report. The facility shall use the sale price in computing the gain or loss on the disposition of assets.

2. Depreciation methods.

a. The straight-line method of depreciation must be used. All accelerated methods of depreciation, including depreciation options made available for income tax purposes, such as those offered under the asset depreciation range system, may not be used. The method and procedure for computing depreciation must be applied on a basis consistent from year to year and detailed schedules of individual assets must be maintained. If the books of account reflect depreciation different than that submitted on the cost report, a reconciliation must be prepared by the facility.

b. Except as provided in subdivision c, a provider shall apply the same methodology for determining the useful lives of all assets purchased after June 30, 1995. If a composite useful life methodology is chosen, the provider may not thereafter use the depreciation guidelines without the department's written approval. The provider shall use, at a minimum, the depreciation guidelines to determine the useful life of buildings and land improvements. The provider may use:

(1) A composite useful life of ten years for all equipment except automobiles and five years for automobiles; or

(2) The useful lives for all equipment identified in the depreciation guidelines and a useful life of ten

years for all equipment not identified in the depreciation guidelines.

c. A provider acquiring assets as an ongoing operation shall use as a basis for determining depreciation:

(1) The estimated remaining life, as determined by a qualified appraiser, for land improvements, buildings, and fixed equipment; and

(2) A composite remaining useful life for movable equipment, determined from the seller's records.

3. Acquisitions.

a. If a depreciable asset has, at the time of its acquisition, a historical cost of at least one thousand dollars, its cost must be capitalized and depreciated over the estimated useful life of the asset. Cost incurred during the construction of an asset, such as architectural, consulting and legal fees, and interest, must be capitalized as a part of the cost of the asset.

b. All repair or maintenance costs in excess of five thousand dollars per project on equipment or buildings must be capitalized and depreciated over the remaining useful life of the equipment or building repaired or maintained, or one-half of the original estimated useful life, whichever is greater.

4. Proper records must provide accountability for the fixed assets and provide adequate means by which depreciation can be computed and established as an allowable resident-related cost. Tagging of major equipment items is not mandatory, but alternate records must exist to satisfy audit verification of the existence and location of the assets.

5. Donated assets, excluding assets acquired as an ongoing operation, may be recorded and depreciated based on their fair market value. In the case where the provider's records do not contain the fair market value of the donated asset, as of the date of the donation, an appraisal may be made. The appraisal must be made by a recognized appraisal expert and may be accepted for depreciation purposes. The useful life of a donated asset must be determined in accordance with subsection 2. The facility may elect to forego depreciation on a donated asset thereby negating the need for a fair market value determination.

6. Basis for depreciation of assets acquired as an ongoing operation. Determination of the cost basis of a facility and its depreciable assets of an ongoing operation depends on whether or not the transaction is a bona fide sale. Should

the issue arise, the purchaser has the burden of proving that the transaction was a bona fide sale. Purchases where the buyer and seller are related organizations are not bona fide.

a. The cost basis of a facility and its depreciable assets acquired in a bona fide sale after July 1, 1985, is limited to the lowest of:

(1) Purchase price paid by the purchaser;

(2) Fair market value at the time of the sale;

(3) The seller's cost basis, increased by one-half of the increase in the consumer price index for all urban consumers, United States city average, all items, from the date of acquisition by the seller to the date of acquisition by the buyer, less accumulated depreciation recognized for cost reporting purposes~~, plus recaptured depreciation~~; or

(4) The seller's cost basis, increased by one-half of the increase in the Dodge construction index from the date of acquisition by the seller to the date of acquisition by the buyer, less accumulated depreciation recognized for cost reporting purposes~~, plus recaptured depreciation~~;

b. In a sale not bona fide, the cost basis of an acquired facility and its depreciable assets is the seller's cost basis, less accumulated depreciation recognized for cost reporting purposes as of the end of the report year immediately preceding the date of acquisition by the buyer.

c. The cost basis of a facility and its depreciable assets acquired by donation or for a nominal amount is the cost basis of the seller or donor, less accumulated depreciation recognized for cost reporting purposes as of the end of the report year immediately preceding the date of acquisition by the buyer or donee.

d. In order to calculate the increase over the seller's cost basis, an increase may be allowed, under subdivision a, only for assets with a historical cost basis established separately and distinctly in the seller's depreciable asset records.

~~7. The seller shall use the sale price in computing the gain or loss on the disposition of assets.~~

~~8. To properly provide for costs or valuations of capital assets, an appraisal is required if the provider has no historical cost records or has incomplete records of capital assets.~~

9. e. An adjustment may not be allowed for any depreciable cost that exceeded the basis in effect for rate periods prior to January 1, 1996.

f. For purposes of this subsection, "date of acquisition" means the date when ownership of the depreciable asset transfers from the transferor to the transferee such that both are bound by the transaction. For purposes of transfers of real property, the date of acquisition is the date of delivery of the instrument transferring ownership. For purposes of titled personal property, the date of acquisition is the date the transferee receives a title acceptable for registration. For purposes of all other capital assets, the date of acquisition is the date the transferee possesses both the asset and an instrument, describing the asset, which conveys the property to the transferee.

~~10.--Recapture-of-depreciation.~~

~~a.--At--any--time--the-owners-of-a-facility-sell-an-asset-in-a bona-fide-sale,-or-otherwise-remove-an-asset-from--service in---or--to--the--facility,--except--as--provided--for--in subdivisions-c-and-d,-any-depreciation-costs-paid--by--the medical---assistance--program--after--June-1,--1984,--with respect-to-that-asset,-are-subject--to--recapture--to--the extent--that--the--sale--or--disposal--price--exceeds--the undepreciated---value.----If---a----facility----terminates participation--as--a--provider--of-services-in-the-medical assistance-program,-except-as-provided--in--subdivisions-c and---d,--any--depreciation--costs--paid--by--the--medical assistance-program-after-June-1,--1984,--with--respect--to that--asset--or--facility,-are-subject-to-recapture-to-the extent-the-fair-market-value--of--the--asset--or--facility exceeds-the-depreciated-value.~~

~~b.--The--seller-and-the-purchaser-may,-by-agreement,-determine who--shall--pay--the--recaptured--depreciation.---If---the depreciation--recapture--amount-is-not-paid-in-full-to-the department-within-thirty-days-after--notification--by--the department--of-the-amount-due,-the-department-shall-offset the-amount-of-depreciation-to-be--recaptured--against--any amounts--owed,--or--to--be--owed,-by-the-department-to-the seller-and-buyer.--The-department-shall-first-exercise-the offset--against--the--seller,--and-shall-only-exercise-the offset-against-the-buyer-to--the--extent--the--seller--has failed-to-repay-the-amount-of-the-recaptured-depreciation, plus-interest.--If-the-depreciation--recapture--amount--is not--paid--in-full-to-the-department-within-thirty-days-of notification-by-the-department-of-the-amount-due,-interest on-the-depreciation-recapture-amount-from-the-date-of-sale is-due-to-the-department-in-addition-to--the--depreciation recapture--amount.---The--interest--accrues-at-the-rate-at~~

~~which interest accrues against the state, under the Cash Management Improvement Act of 1990, [Pub. L. 101-453; 31 U.S.C. 6501 et seq.] for refunds of federal medicaid funds received by the state, but not repaid to the federal agency, or six percent per annum, whichever is greater. Depreciation recapture amounts and interest payments made thereon to the department and the cost of borrowing for the purpose of repaying recaptured depreciation and interest on recaptured depreciation are not costs related to resident care.~~

~~c. If a facility has been owned twenty years or longer at the time a sale, removal from service, or termination of participation occurs, there may be no recapture of depreciation.~~

~~d. If a facility has been owned more than ten years, but fewer than twenty years at the time a sale, removal from service, or termination of participation in the medical assistance program occurs, the depreciation recapture amount determined in subdivision a must be decreased by a percentage equal to ten times the number of full years the facility was owned after the tenth year.~~

~~11.~~ 7. A per bed cost limitation based on single and double occupancy must be used to determine the total allowable cost basis of buildings and fixed equipment for a facility with construction, renovation, or remodeling.

a. The per bed limitation basis for double occupancy must be calculated averaging the cost basis reported on the June 30, 1994, cost report, as adjusted by the ~~Dodge construction index~~ consumer price index for all urban consumers, United States city average, all items, to June 30, 1995, for nonstate-owned facilities with construction of new occupancy space completed on or after January 1, 1990, and before July 1, 1994.

b. The per bed limitation basis for single occupancy must be calculated using the limitation determined in subdivision a, multiplied by 1.34.

c. The double and single occupancy per bed limitation must be adjusted annually on July first, using the ~~Dodge construction index~~ increase, if any, in the consumer price index for all urban consumers, United States city average, all items, for the twelve-month period ending the preceding May thirty-first.

d. The per bed limitation in effect at the time a construction, renovation, or remodeling project is put in service must be multiplied times the number of beds in

double and single occupancy rooms to establish the maximum allowable cost basis of buildings and fixed equipment.

e. The cost basis of a facility's buildings and fixed equipment must be limited to the lower of the recorded cost of total facility buildings and fixed equipment or the per bed limitation.

f. The per bed limitation is not applicable to projects started or approved by the state health council before July 1, 1994.

History: Effective September 1, 1980; amended effective December 1, 1983; October 1, 1984; September 1, 1987; January 1, 1990; January 1, 1992; November 22, 1993; January 1, 1996; January 1, 1998.
General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4; 42 USC 1396a(a)(13)

75-02-06-10. Bad debts.

1. Bad debts for charges incurred on or after January 1, 1990, and fees paid for the collection of those bad debts, are allowable, provided all the requirements of this subsection are met.

   a. The bad debt must result from nonpayment of the payment rate or part of the payment rate.

   b. The facility shall document that reasonable collection efforts have been made, the debt was uncollectible, and there is no likelihood of future recovery. Reasonable collection efforts include pursuing all avenues of collection available to the facility, including liens and judgments. In instances where the bad debt is owed by a person determined to have made a disqualifying transfer or assignment of property for the purpose of securing eligibility for medical assistance benefits, the facility shall document that it has made all reasonable efforts to secure payment from the transferee, including the bringing of an action for a transfer in fraud of creditors.

   c. The collection fee may not exceed the amount of the bad debt.

   d. The bad debt may not result from the facility's failure to comply with federal and state laws, state rules, and federal regulations.

   e. The bad debt may not result from nonpayment of a private room rate in excess of the established rate, charges for special services not included in the established rate, or charges for bed hold days not billable to the medical

assistance program under subsections 3, 4, and 5, and 6 of section 75-02-06-14.

f. The facility shall have an aggressive policy of avoiding bad debt expense that limits potential bad debts. The facility shall document that the facility has taken action to limit bad debts for individuals who refuse to make payment.

2. Allowable bad debt expense may not exceed one hundred twenty days of resident care for any one individual.

3. Finance charges on bad debts allowable under subsections 1 and 2 are allowable only if the finance charges have been offset as interest income.

History: Effective September 1, 1980; amended effective December 1, 1983; January 1, 1990; November 22, 1993; January 1, 1996; January 1, 1998.
General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4; 42 USC 1396a(a)(13)

75-02-06-12. Offsets to cost.

1. Several items of income must be considered as offsets against various costs as recorded in the books of the facility. Income in any form received by the facility, with the exception of an established rate, income from payments made under the Job Training Partnership Act, and income from charges for private rooms, special services, or bed holds must be offset up to the total of the appropriate actual allowable cost. If actual costs are not identifiable, income must be offset up to the total of costs described in this section. If costs relating to income are reported in more than one cost category, the income must be offset in the ratio of the costs in each cost category. Sources of income include:

   a. "Activities income". Income from the activities department and the gift shop must be offset to activity costs.

   b. "Dietary income". Amounts received from or on behalf of employees, guests, or other nonresidents for lunches, meals, or snacks must be offset to dietary and food costs.

   c. "Drugs or supplies income". Amounts received from employees, doctors, or others not admitted as residents must be offset to nursing supplies. Medicare part B income for drugs and supplies must be offset to nursing supplies.

d. "Insurance recoveries income". Any amount received from insurance for a loss incurred must be offset against the appropriate cost category, regardless of when or if the cost is incurred, if the facility did not adjust the basis for depreciable assets.

e. "Interest or investment income". Interest received on investments, except amounts earned on funded depreciation or from earnings on gifts where the identity remains intact, must be offset to interest expense.

f. "Laundry income". All amounts received for laundry services rendered to or on behalf of employees, doctors, or others must be offset to laundry costs.

g. "Private duty nurse income". Income received for the providing of a private duty nurse must be offset to nursing salaries.

h. "Rentals of facility space income". Income received from outside sources for the use of facility space and equipment must be offset to property costs.

i. "Telegraph and telephone income". Income received from residents, guests, or employees must be offset to administration costs. Income from emergency answering services need not be offset.

j. "Therapy income". Except for income from medicare part A, income from therapy services, <u>including medicare part B income,</u> must be offset to therapy costs unless the provider has elected to make therapy costs nonallowable under subsection 40 of section 75-02-06-12.1.

k. "Vending income". Income from the sale of beverages, candy, or other items must be offset to the cost of the vending items or, if the cost is not identified, all vending income must be offset to the cost category where vending costs are recorded.

l. "Bad debt recovery". Income for bad debts previously claimed must be offset to administrative costs in total in the year of recovery.

m. "Other cost-related income". Miscellaneous income, including amounts generated through the sale of a previously expensed or depreciated item, e.g., supplies or equipment, must be offset, in total, to the cost category where the item was expensed or depreciated.

2. Payments to a provider by its vendor must ordinarily be treated as purchase discounts, allowances, refunds, or rebates, even though these payments may be treated as

"contributions" or "unrestricted grants" by the provider and the vendor. Payments that represent a true donation or grant need not be treated as purchase discounts, allowances, refunds, or rebates. Examples of payments that represent a true donation or grant include contributions made by a vendor in response to building or other fundraising campaigns in which communitywide contributions are solicited or when the volume or value of purchases is so nominal that no relationship to the contribution can be inferred. The provider shall provide verification, satisfactory to the department, to support a claim that a payment represents a true donation.

3. Where an owner, agent, or employee of a provider directly receives from a vendor monetary payments or goods or services for the owner's, agent's, or employee's own personal use as a result of the provider's purchases from the vendor, the value of the payments, goods, or services constitutes a type of refund or rebate and must be applied as a reduction of the provider's costs for goods or services purchased from the vendor.

4. Where the purchasing function for a provider is performed by a central unit or organization, all discounts, allowances, refunds, and rebates must be credited to the costs of the provider and may not be treated as income by the central unit or organization or used to reduce the administrative costs of the central unit or organization.

5. Purchase discounts, allowances, refunds, and rebates are reductions of the cost of whatever was purchased.

6. For purposes of this section, "medicare part B income" means the interim payment made by medicare during the report year plus any cost settlement payments made to the provider or due from the provider for previous periods which are made during the report year and which have not been reported to the department prior to June 30, 1997.

History: Effective September 1, 1980; amended effective December 1, 1983; October 1, 1984; September 1, 1987; June 1, 1988; January 1, 1990; January 1, 1992; November 22, 1993; January 1, 1996; January 1, 1998.
General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4; 42 USC 1396a(a)(13)

75-02-06-12.1. Nonallowable costs. Costs not related to resident care are costs not appropriate or necessary and proper in developing and maintaining the operation of resident care facilities and activities. These costs are not allowed in computing the rates. Nonallowable costs include:

1. Political contributions;

2. Salaries or expenses of a lobbyist;

3. Advertising designed to encourage potential residents to select a particular facility;

4. Fines or penalties, including interest charges on the penalty, bank overdraft charges, and late payment charges;

5. Legal and related expenses for challenges to decisions made by governmental agencies except for successful challenges as provided for in section 75-02-06-02.5;

6. Costs incurred for activities directly related to influencing employees with respect to unionization;

7. Cost of memberships in sports, health, fraternal, or social clubs or organizations, such as elks, country clubs, knights of columbus;

8. Assessments made by or the portion of dues charged by associations or professional organizations for lobbying costs, contributions to political action committees or campaigns, or litigation, except for successful challenges to decisions made by governmental agencies (including all dues unless an allocation of dues to such costs is provided);

9. Community contributions, employer sponsorship of sports teams, and dues to civic and business organizations, i.e., lions, chamber of commerce, or kiwanis, in excess of one thousand five hundred dollars per cost reporting period;

10. Home office costs not otherwise allowable if incurred directly by the facility;

11. Stockholder servicing costs incurred primarily for the benefit of stockholders or other investors that include annual meetings, annual reports and newsletters, accounting and legal fees for consolidating statements for security exchange commission purposes, stock transfer agent fees, and stockholder and investment analysis;

12. Corporate costs not related to resident care, including reorganization costs; costs associated with acquisition of capital stock, except otherwise allowable interest and depreciation expenses associated with a transaction described in subsection 3 of section 75-02-06-07; and costs relating to the issuance and sale of capital stock or other securities;

13. The full cost of items or services such as telephone, radio, and television, including cable hookups or satellite dishes, located in resident accommodations, excluding common areas, furnished solely for the personal comfort of the residents;

14. Fundraising costs, including salaries, advertising, promotional, or publicity costs incurred for such a purpose;

15. The cost of any equipment, whether owned or leased, not exclusively used by the facility except to the extent that the facility demonstrates, to the satisfaction of the department, that any particular use of equipment was related to resident care;

16. Costs, including, by way of illustration and not by way of limitation, legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies, attributed to the negotiation or settlement of the sale or purchase of any capital assets, whether by sale or merger, when the cost of the asset has been previously reported and included in the rate paid to any hospital or facility;

17. Costs incurred by the provider's subcontractors, or by the lessor of property that the provider leases, that are an element in the subcontractor's or lessor's charge to the provider, if the costs would not have been allowable had the costs been incurred by a provider directly furnishing the subcontracted services, or owning the leased property except no facility shall have a particular item of cost disallowed under this subsection if that cost arises out of a transaction completed before July 18, 1984;

18. The cost, in excess of charges, of providing meals and lodging to facility personnel living on premises;

19. Depreciation expense for facility assets not related to resident care;

20. Nonnursing facility operations and associated administration costs;

21. Direct costs or any amount claimed to medicare for medicare utilization review costs;

22. All costs for services paid directly by the department to an outside provider, such as prescription drugs;

23. Travel costs involving the use of vehicles not exclusively used by the facility except to the extent:

    a. The facility supports vehicle travel costs with sufficient documentation to establish that the purpose of the travel is related to resident care;

    b. Resident-care related vehicle travel costs do not exceed a standard mileage rate established by the internal revenue service; and

c. The facility documents all costs associated with a vehicle not exclusively used by the facility;

24. Travel costs other than vehicle-related costs unless supported, reasonable, and related to resident care;

25. Additional compensation paid to an employee, who is a member of the board of directors, for service on the board;

26. Fees paid to a member of a board of directors for meetings attended to the extent that the fees exceed the compensation paid, per day, to a member of the legislative council, pursuant to North Dakota Century Code section 54-35-10;

27. Travel costs associated with a board of directors meeting to the extent the meeting is held in a location where the organization has no facility;

28. The costs of deferred compensation and pension plans that discriminate in favor of certain employees, excluding the portion of the cost which relates to costs that benefit all eligible employees;

29. Employment benefits associated with salary costs not includable in a rate set under this chapter.

30. Premiums for top management personnel life insurance policies, except that the premiums must be allowed if the policy is included within a group policy provided for all employees, or if the policy is required as a condition of mortgage or loan and the mortgagee or lending institution is listed as the sole beneficiary;

31. Personal expenses of owners and employees, including vacations, personal travel, and entertainment;

32. Costs not adequately documented through written documentation, date of purchase, vendor name, listing of items or services purchased, cost of items purchased, account number to which the cost is posted, and a breakdown of any allocation of costs between accounts or facilities;

33. The following taxes:

    a. Federal income and excess profit taxes, including any interest or penalties paid thereon;

    b. State or local income and excess profit taxes;

    c. Taxes in connection with financing, refinancing, or refunding operation, such as taxes on the issuance of bonds, property transfers, or issuance or transfer of stocks, which are generally either amortized over the life

of the securities or depreciated over the life of the asset, but not recognized as tax expense;

d. Taxes, including real estate and sales tax, for which exemptions are available to the provider;

e. Taxes on property not used in the provision of covered services;

f. Taxes, including sales taxes, levied against the residents and collected and remitted by the provider;

g. Self-employment (FICA) taxes applicable to persons including individual proprietors, partners, members of a joint venture;

34. The unvested portion of a facility's accrual for sick or annual leave;

35. The cost, including depreciation, of equipment or items purchased with funds received from a local or state agency, exclusive of any federal funds;

36. Hair care, other than routine hair care, furnished by the facility;

37. The cost of education unless:

a. The education was provided by an accredited academic or technical educational facility;

b. The expenses were for materials, books, or tuition;

c. The employee was enrolled in a course of study intended to prepare the employee for a position at the facility, and is in that position; and

d. The facility claims the cost of the education at a rate that does not exceed one dollar per hour of work performed by the employee in the position for which the employee received education at the facility's expense, provided the amount claimed per employee may not exceed two thousand dollars per year, or an aggregate of eight thousand dollars, and in any event may not exceed the cost to the facility of the employee's education.

38. Interest expense on the portion of operating loans equal to nonallowable costs incurred for the current and prior reporting periods;

39. Increased lease costs of a facility, unless:

a. The lessor incurs increased costs related to the ownership of the facility or a resident-related asset;

b. The increased costs related to the ownership are charged to the lessee; and

c. The increased costs related to the ownership would be allowable had the costs been incurred directly by the lessee;

40. At the election of the provider, the direct and indirect costs of providing therapy services to nonnursing facility residents or medicare part B therapy services, including purchase of service fees and operating or property costs related to providing therapy services.;

41. Costs associated with or paid for the acquisition of licensed nursing facility capacity;

42. Goodwill; and

43. Lease costs in excess of the amount allocable to the leased space as reported on the medicare cost report by a lessor who provides services to recipients of benefits under title XVIII or title XIX of the Social Security Act.

History: Effective January 1, 1990; amended effective January 1, 1992; November 1, 1992; November 22, 1993; January 1, 1996; July 1, 1996; January 1, 1998.
General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4; 42 USC 1396a(a)(13)

75-02-06-14. Resident days.

1. A resident day is any day for which service is provided or for which payment is ordinarily sought for us of a bed. The amount of remuneration has no bearing on whether a day should be counted.

2. Adequate census records must be prepared and maintained on a daily basis by the facility to allow for proper audit of the census data. The daily census records must include:

a. Identification of the resident;

b. Entries for all days, and not just by exception;

c. Identification of type of day, i.e., hospital, in-house;

d. Identification of the resident's classification; and

e. Monthly totals by resident, by classifications for all residents, and by type of day.

3. A maximum of fifteen days per occurrence may be allowed for payment by the medical assistance program for hospital leave. Hospital days in excess of fifteen consecutive days not billable to the medical assistance program are not resident days unless any payment is sought as provided for in subdivision c of subsection 1 of section 75-02-06-22.

4. A maximum of eighteen therapeutic leave days per rate year may be allowed for payment by the medical assistance program. Therapeutic leave days in excess of eighteen per year are not resident days unless any payment is sought as provided for in subdivision c of subsection 1 of section 75-02-06-22.

5. Institutional leave days are not billable to the department and are not resident days unless any payment is sought as provided for in subdivision c of subsection 1 of section 75-02-06-22.

6. Hospital and therapeutic leave days, occurring immediately following a period when a resident was receiving medicare part A benefits in the facility, are not billable to the department and are not resident days unless any payment is sought as provided for in subdivision c of subsection 1 of section 75-02-06-22.

7. Residents admitted to the facility through a hospice program or electing hospice benefits while in a facility must be identified as hospice residents for census and billing purposes.

History: Effective September 1, 1980; amended effective December 1, 1983; September 1, 1987; January 1, 1990; November 1, 1992; November 22, 1993; January 1, 1996; January 1, 1998.
General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4; 42 USC 1396a(a)(13)

75-02-06-16. Rate determinations.

1. For each cost category, the actual rate is calculated using allowable historical operating costs and adjustment factors provided for in subsection 4 divided by standardized resident days for the direct care cost category and resident days for other direct care, indirect care, and property cost categories. The actual rate as calculated is compared to the limit rate for each cost category to determine the lesser of the actual rate or the limit rate. The lesser rate is given the rate weight of one. The rate weight of one for direct care is then multiplied times the weight for each classification in subsection 5 of section 75-02-06-17 to

establish the direct care rate for that classification. The lesser of the actual rate or the limit rate for other direct care, indirect care, and property costs, and the adjustments provided for in subsections 2 and 3 are then added to the direct care rate for each classification to arrive at the established rate for a given classification.

2. a. For a facility with an actual rate below the limit rate for indirect care costs, an incentive amount equal to seventy percent times the difference between the actual rate, exclusive of the adjustment factor, and the limit rate in effect at the end of the year immediately preceding the rate year, up to a maximum of two dollars and sixty cents must be included as part of the indirect care cost rate.

   b. A facility shall receive an operating margin of three percent based on the lesser of the actual direct care and other direct care rates, exclusive of the adjustment factor, or the limit rate in effect at the end of the year immediately preceding the rate year. The three percent operating margin must be added to the rate for the direct care and other direct care cost categories.

   ~~c.--Notwithstanding--the--provisions--of-subdivisions-a-and-b, for-the-last--five--months--of--the--rate--year--beginning January-1,--1994,--the--limit--rate--used-to-determine-the operating-margin-for-the--direct--care--cost--category--is thirty-one--dollars--and--twenty-two-cents,-the-limit-rate used-to-determine--the--operating--margin--for--the--other direct--care--cost--category-is-ten-dollars-and-thirty-one cents,-and-the-limit-rate-used-to-determine-the--incentive for--the--indirect--care-cost-rate-is-twenty-three-dollars and-thirty-two-cents.~~

3. Limitations.

   a. The department shall accumulate and analyze statistics on costs incurred by facilities. Statistics may be used to establish reasonable ceiling limitations and incentives for efficiency and economy based on reasonable determination of standards of operations necessary for efficient delivery of needed services. Limitations and incentives may be established on the basis of cost of comparable facilities and services and may be applied as ceilings on the overall costs of providing services or on specific areas of operations. The department may implement ceilings at any time based upon information available.

   b. The department shall review, on an ongoing basis, aggregate payments to facilities to determine that payments do not exceed an amount that can reasonably be

estimated would have been paid for those services under medicare payment principles. If aggregate payments to facilities exceed estimated payments under medicare, the department may make adjustments to rates to establish the upper limitations so that aggregate payments do not exceed an amount that can be estimated would have been paid under medicare payment principles.

c. All facilities except those nongeriatric physically handicapped facilities described in North Dakota Century Code section 50-24.4-13 must be used to establish a limit rate for the direct care, other direct care, and indirect care cost categories. The base year is the report year ended June 30, 1992. Base year costs may not be adjusted in any manner or for any reason not provided for in this subsection.

(1) The limit rate for each of the cost categories must be established as follows:

(a) Historical costs for the report year ended June 30, 1992, as adjusted, must be used to establish rates for all facilities in the direct care, other direct care, and indirect care cost categories.

(b) ~~For the first seven months of the rate year beginning January 1, 1994, the rates as established in subparagraph a of this paragraph must be ranked from low to high for each cost category. The eightieth percentile ranking must be determined for the direct care and other direct care cost categories, and the sixtieth percentile ranking must be determined for the indirect care cost category. The rate of each facility so ranked must be multiplied times 1.05165 to establish the limit rate for each category.~~

~~(c)~~ For the ~~last five months of the~~ rate year beginning January 1, ~~1994~~ 1997, the limit rate for the direct care cost category is ~~thirty-two~~ thirty-four dollars and ~~three~~ eighty-three cents, for the other direct care cost category is ~~ten~~ eleven dollars and ~~fifty-eight~~ fifty-one cents, and for the indirect care cost category is ~~twenty-three~~ twenty-six dollars and ~~ninety-three~~ three cents.

~~(d)~~ (c) For the rate ~~year~~ years beginning January 1, ~~1995~~ 1998, and January 1, 1999, the limit rates established in subparagraph ~~c~~ b must be multiplied times the ~~consumer price~~ appropriate

composite economic change index increase (as described in subsection 4) to establish the limit rate for each cost category.

~~(e)~~ (d) For rate years beginning on or after January 1, ~~1996~~ 2000, the limit rate set for each cost category for the previous rate year must be multiplied times the ~~consumer price~~ appropriate composite economic change index increase (as described in subsection 4)~~, if any,~~ to establish the limit rate for each cost category.

(2) A facility with an actual rate that exceeds the limit rate for a cost category shall receive the limit rate.

d. The actual rate for indirect care costs and property costs must be the lesser of the rate established using actual census or ninety percent of licensed bed capacity available for occupancy. A licensed bed is not available for occupancy if the licensed bed is part of a remodeling, renovation, or construction project for the period the bed is not in service.

e. The department may waive or reduce the application of subdivision d if the facility demonstrates that occupancy below ninety percent of licensed capacity results from the use of alternative home and community services by individuals who would otherwise be eligible for admission to the facility and:

(1) The facility has reduced licensed capacity; or

(2) The facility's governing board has approved a capacity decrease to occur no later than the end of the rate year which would be affected by subdivision d.

4. Adjustment factors for direct care, other direct care, and indirect care costs. ~~The department has determined that the appropriate economic change index, for purposes of subsection 5 of North Dakota Century Code section 50-24.4-10, is the increase, if any, in the consumer price index for urban wage earners and clerical workers (CPI-W), all items, United States city average.~~

a. An appropriate composite economic change index may be used for purposes of adjusting historical costs for direct care, other direct care, and indirect care under subsection 1 and for purposes of adjusting limitations of direct care costs, other direct care costs, and indirect care costs under subsection 3, but may not be used to

adjust property costs under either subsection 1 or subsection 3.

b. For purposes of this ~~subsection,-the~~ section:

(1) "Appropriate composite economic change index" means:

(a) For the rate year beginning January 1, 1998, and the rate year beginning January 1, 1999, one-half of the increase, if any, in the consumer price index, plus one-half of the increase, if any, in the data resources, incorporated, North Dakota specific nursing home input price index; and

(b) For the rate years beginning on or after January 1, 2000, the increase in the consumer price index, if any.

(2) The "consumer price index increase" means the percentage (rounded to the nearest one-tenth of one percent) by which ~~that~~ consumer price index for urban wage earners and clerical workers (CPI-W), all items, United States city average for the quarter ending September thirtieth of the year immediately preceding the rate year (as prepared by the United States department of labor) exceeds that index for the quarter ending September thirtieth of the second year preceding the rate year. ~~The--consumer--price index--increase--must--be-used-to-adjust-direct-care, other-direct-care,-and-indirect-care-costs.~~

(3) "Data resources, incorporated, North Dakota specific nursing home input price index" means:

(a) For purposes of determining the adjustment factor applicable to historical costs under subsection 1, for direct care, other direct care, and indirect care, the composite index for the eighteen-month period beginning immediately after the report year ends; and

(b) For purposes of determining the adjustment factor applicable to the limit rates for direct care, other direct care, and indirect care under subsection 3, the composite index for the period beginning January 1, 1998, and ending at the end of the rate year.

5. Rate adjustments.

a. Desk audit rate.

(1) The cost report must be reviewed taking into consideration the prior year's adjustments. The facility must be notified by telephone or mail of any adjustments based on the desk review. Within seven working days after notification, the facility may submit information to explain why the desk adjustment should not be made. The department shall review the information and make appropriate adjustments.

(2) The desk audit rate must be effective January first of each rate year unless the department specifically identifies an alternative effective date and must continue in effect until a final rate is established.

(3) Until a final rate is effective, pursuant to paragraph 3 of subdivision b of this subsection, private-pay rates may not exceed the desk audit rate except as provided for in section 75-02-06-22 or subdivision c.

(4) The facility may request a reconsideration of the desk rate for purposes of establishing a pending decision rate. The request for reconsideration must be filed with the department's medical services division within thirty days of the date of the rate notification and must contain the information required in subsection 1 of section 75-02-06-26. No decision on the request for reconsideration of the desk rate may be made by the department unless, after the facility has been notified that the desk rate is the final rate, the facility asks requests, in writing within thirty days of the rate notification, the department to issue a decision on that request for reconsideration.

(5) The desk rate may be adjusted for special rates or one-time adjustments provided for in this section.

(6) The desk rate may be adjusted to reflect errors, adjustments, or omissions for the report year that result in a change of at least five cents per day for the rate weight of one.

b. Final rate.

(1) The cost report may be field audited to establish a final rate. If no field audit is performed, the desk audit rate must become the final rate upon notification from the department. The final rate is effective January first of each rate year unless the department specifically identifies an alternative effective date.

(2) The final rate must include any adjustments for nonallowable costs, errors, or omissions that result in a change from the desk audit rate of at least five cents per day for the rate weight of one that are found during a field audit or are reported by the facility within twelve months of the rate yearend.

(3) The private-pay rate must be adjusted to the final rate no later than the first day of the second month following receipt of notification by the department of the final rate and is not retroactive except as provided for in subdivision c of this subsection.

(4) The final rate may be revised at any time for special rates or one-time adjustments provided for in this section.

(5) If adjustments, errors, or omissions are found after a final rate has been established, the following procedures must be used:

(a) Adjustments, errors, or omissions found within twelve months of establishment of the final rate, not including subsequent revisions, resulting in a change of at least five cents per day for the rate weight of one must result in a change to the final rate. The change must be applied retroactively as provided for in this section.

(b) Adjustments, errors, or omissions found later than twelve months after the establishment of the final rate, not including subsequent revisions, that would have resulted in a change of at least five cents per day for the rate weight of one had they been included, must be included as an adjustment in the report year that the adjustment, error, or omission was found.

(c) Adjustments resulting from an audit of home office costs, that result in a change of at least five cents per day for the rate weight of one, must be included as an adjustment in the report year in which the costs were incurred.

(d) The two report years immediately preceding the report year to which the adjustments, errors, or omissions apply may also be reviewed for similar adjustments, errors, or omissions.

c. Pending decision rates for private-pay residents.

(1) If a facility has made a request for reconsideration, taken an administrative appeal, or taken a judicial appeal from a decision on an administrative appeal, and has provided information sufficient to allow the department to accurately calculate, on a per day basis, the effect of each of the disputed issues on the facility's rate, the department shall determine and issue a pending decision rate within thirty days of receipt of the request for reconsideration, administrative appeal, or judicial appeal. If the information furnished is insufficient to determine a pending decision rate, the department, within thirty days of receipt of the request for reconsideration, shall inform the facility of the insufficiency and may identify information that would correct the insufficiency.

(2) The department shall add the pending decision rate to the rate that would otherwise be set under this chapter, and, notwithstanding North Dakota Century Code section 50-24.4-19, the total must be the rate chargeable to private-paying residents until a final decision on the request for reconsideration or appeal is made and is no longer subject to further appeal. The pending decision rate is subject to any rate limitation that may apply.

(3) The facility shall establish and maintain records that reflect the amount of any pending decision rate paid by each private-paying resident from the date the facility charges a private-paying resident the pending decision rate.

(4) If the pending decision rate paid by a private-paying resident exceeds the final decision rate, the facility shall refund the difference, plus interest accrued at the legal rate from the date of notification of the pending decision rate, within sixty days after the final decision is no longer subject to appeal. If a facility fails to provide a timely refund to a living resident or former resident, the facility shall pay interest at three times the legal rate for the period after the refund is due. If a former resident is deceased, the facility shall pay the refund to a person lawfully administering the estate of the deceased former resident or lawfully acting as successor to the deceased former resident. If no person is lawfully administering the estate or lawfully acting as a successor, the facility may make any disposition of the refund permitted by law. Interest paid under this subsection is not an allowable cost.

d. The final rate as established must be retroactive to the effective date of the desk rate, except with respect to rates paid by private-paying residents. A rate paid by a private-pay resident must be retroactively adjusted and the difference refunded to the resident, if the rate paid by the private-pay resident exceeds the final rate by at least twenty-five cents per day, except that a pending decision rate is not subject to adjustment or refund until a decision on the disputed amount is made.

6. Rate payments.

a. The rate as established must be considered as payment for all accommodations and includes all items designated as routinely provided. No payments may be solicited or received from the resident or any other person to supplement the rate as established.

b. The rate as established must be paid by the department only if the rate charged to private-pay residents for semiprivate accommodations equals the established rate. If at any time the facility discounts rates for private-pay residents, the discounted rate must be the maximum chargeable to the department for the same bed type, i.e., hospital or leave days.

c. If the established rate exceeds the rate charged to a private-pay resident, on any given date, the facility shall immediately report that fact to the department and charge the department at the lower rate. If payments were received at the higher rate, the facility shall, within thirty days, refund the overpayment. The refund must be the difference between the established rate and the rate charged the private-pay resident times the number of medical assistance resident days paid during the period in which the established rate exceeded the rate charged to private-pay residents, plus interest calculated at two percent over the Bank of North Dakota prime rate on any amount not repaid within thirty days. The refund provision also applies to all duplicate billings involving the department. Interest charges on these refunds are not allowable costs.

d. Peer groupings, limitations, or adjustments based upon data received from or relating to more than one facility are effective for a rate period. Any change in the data used to establish peer groupings, limitations, or adjustments may not be used to change such peer groupings, limitations, or adjustments during the rate period, except with respect to the specific facility or facilities to which the data change relates.

e. The established rate is paid based on a prospective ratesetting procedure. No retroactive settlements for actual costs incurred during the rate year that exceed the established rate may be made unless specifically provided for in this section.

7. Partial year.

a. ~~For~~ Rates for a facility changing ownership during the rate period~~,-the-rate~~ are set under this subdivision.

(1) The rates established for direct care, other direct care, indirect care, operating margins, and incentives for the previous owner must be retained~~.~~ ~~The-rate~~ through the end of the rate period and the rates for the next rate period following the change in ownership must be established:

~~(1)~~ (a) For a facility with four or more months of operation under the new ownership during the report year, through use of a cost report for the period; and

~~(2)~~ (b) For a facility with less than four months of operation under the new ownership during the report year, by indexing the ~~rate~~ rates established for the previous owner forward using the adjustment ~~factors~~ factor in subsection 4.

(2) Unless a facility elects to have a property rate established under paragraph 3, the rate established for property for the previous owner must be retained through the end of the rate period and the property rate for the next rate period following the change in ownership must be established:

(a) For a facility with four or more months of operation under the new ownership during the report year, through use of a cost report for the period; and

(b) For a facility with less than four months of operation under the new ownership during the report year, by using the rate established for the previous owner for the previous rate year.

(3) A facility may choose to have a property rate established, during the remainder of the rate year and the subsequent rate year, based on interest and principal payments on the allowable portion of debt to be expended during the rate years. The property rate must go into effect on the first of the month following notification by the department. The

difference between a property rate established based on the facility's election and a property rate established based on paragraph 2, multiplied by actual census for the period, must be determined. The property rate paid in each of the twelve years, beginning with the first rate year following the use of a property rate established using this paragraph, may not exceed the property rate otherwise allowable, reduced by one-twelfth of that difference.

b. For a new facility, the department shall establish an interim rate equal to the limit rates for direct care, other direct care, and indirect care in effect for the rate year in which the facility begins operation, plus the property rate. The property rate must be calculated using projected property costs and projected census. The interim rate must be in effect for no less than ten months and no more than eighteen months. Costs for the period in which the interim rate is effective must be used to establish a final rate. If the final rates for direct care, other direct care, and indirect care costs are less than the interim rates for those costs, a retroactive adjustment as provided for in subsection 5 must be made. A retroactive adjustment to the property rate must be made to adjust projected property costs to actual property costs. For the rate period following submission of any partial year cost report by a facility, census used to establish rates for property and indirect care costs must be the greater of actual census, projected census, or census imputed at ninety-five percent of licensed beds.

(1) If the effective date of the interim rate is on or after March first and on or before June thirtieth, the interim rate must be effective for the remainder of that rate year and must continue through June thirtieth of the subsequent rate year. The facility shall file by March first an interim cost report for the period ending December thirty-first of the year in which the facility first provides services. The interim cost report is used to establish the actual rate effective July first of the subsequent rate year. The partial year rate established based on the interim cost report must include applicable incentives, margins, phase-ins, and adjustment factors and may not be subject to any cost settle-up. The cost reports for the report year ending June thirtieth of the current and subsequent rate years must be used to determine the final rate for the periods that the interim rate was in effect.

(2) If the effective date of the interim rate is on or after July first and on or before December thirty-first, the interim rate must remain in effect

through the end of the subsequent rate year. The facility shall file a cost report for the partial report year ending June thirtieth of the subsequent rate year. This cost report must be used to establish the rate for the next subsequent rate year. The facility shall file by March first an interim cost report for the period July first through December thirty-first of the subsequent rate year. The interim cost report is used, along with the report year cost report, to determine the final rate for the periods the interim rate was in effect.

(3) If the effective date of the interim rate is on or after January first and on or before February twenty-ninth, the interim rate must remain in effect through the end of the rate year in which the interim rate becomes effective. The facility shall file a cost report for the period ending June thirtieth of the current rate year. This cost report must be used to establish the rate for the subsequent rate year. The facility shall file by March first an interim cost report for the period July first through December thirty-first of the current rate year. The interim cost report is used, along with the report year cost report, to determine the final rate for the period that the interim rate was in effect.

(4) The final rate for direct care, other direct care, and indirect care costs established under this subdivision must be limited to the lesser of the limit rate for the current rate year or the actual rate.

c. For a facility with renovations or replacements in excess of one hundred thousand dollars, and without a significant capacity increase, the rate established for direct care, other direct care, and indirect care, based on the last report year, plus a property rate calculated based on projected property costs and imputed census, must be applied to all licensed beds. The projected property rate must be effective at the time the project is completed and placed into service. The property rate for the subsequent rate year must be based on projected property costs and imputed census, rather than on property costs actually incurred in the report year. Imputed census is based on the greater of actual census of all licensed beds existing before the renovation or ninety percent of the available licensed beds existing prior to renovation, plus ninety-five percent of the increase in licensed bed capacity and unavailable licensed beds existing prior to the renovation. Subsequent property rates must be adjusted using this methodology, except imputed census must be actual census if actual census exceeds ninety-five

percent of total licensed capacity, until such time as twelve months of property costs are reflected in the report year.

d. For a facility with a significant capacity increase, the rate established for direct care, other direct care, and indirect care, based on the last report year, must be applied to all licensed beds. An interim property rate must be established based on projected property costs and projected census. The interim property rate must be effective from the first day of the month beginning after the date in which the increase in licensed beds is issued by the department of health through the end of the rate year. The facility shall file by March first an interim property cost report following the rate year. The interim cost report is used to determine the final rate for property and to establish the amount for a retroactive cost settle-up. The final rate for property is limited to the lesser of the interim property rate or a rate based upon actual property costs. The property rate for the subsequent rate year must be based on projected property costs and census imputed as ninety-five percent of licensed beds, rather than on property costs actually incurred during the report year; and may not be subject to retroactive costs settle-up. Subsequent property rates must be adjusted using this methodology, except imputed census must be actual census if actual census exceeds ninety-five percent of total licensed capacity, until such time as twelve months of property costs are reflected in the report year.

e. For a facility with no significant capacity increase and no renovations or replacements in excess of one hundred thousand dollars, the established rate based on the report year must be applied throughout the rate year for all licensed beds.

f. For a facility terminating its participation in the medical assistance program, whether voluntarily or involuntarily, the department may authorize the facility to receive continued payment until medical assistance residents can be relocated to facilities participating in the medical assistance program.

g. At such time as twelve months of property costs are reflected in the report year, the difference between a projected property rate established using subdivision c or d and the property rate that would otherwise be established based on historical costs must be determined. The property rate paid in each of the twelve years, beginning with the first rate year following the use of a property rate established using subdivision c or d may not

exceed the property rate otherwise allowable, reduced by one-twelfth of that difference.

8. One-time adjustments.

a. Adjustments to meet certification standards.

(1) The department may provide for an increase in the established rate for additional costs incurred to meet certification standards. The survey conducted by the state department of health must clearly require that the facility take steps to correct deficiencies dealing with resident care. The plan of correction must identify the salary and other costs that must be increased to correct the deficiencies cited in the survey process.

(2) The facility shall submit a written request to the medical services division within thirty days of submitting the plan of correction to the state department of health. The request must:

(a) Include a statement that costs or staff numbers have not been reduced for the report year immediately preceding the state department of health's certification survey;

(b) Identify the number of new staff or additional staff hours and the associated costs required to meet the certification standards; and

(c) Provide a detailed list of any other costs necessary to meet survey standards.

(3) The department shall review the submitted information and may request additional documentation or conduct onsite visits. If an increase in costs is approved, the established rate must be adjusted to an amount not to exceed the limit rate.

(4) Any additional funds provided must be used in accordance with the facility's written request to the department and are subject to audit. If the department determines the funds were not used for the intended purpose, an adjustment must be made in accordance with subsection 5.

b. Adjustments for unforeseeable expenses.

(1) The department may provide for an increase in the established rate for additional costs incurred to meet major unforeseeable expenses. The expenses must

be resident related and must be beyond the control of those responsible for the management of the facility.

(2) Within sixty days after first incurring the unforeseeable expense, the facility shall submit a written request to the medical services division containing the following information:

(a) An explanation as to why the facility believes the expense was unforeseeable;

(b) An explanation as to why the facility believes the expense was beyond the managerial control of the facility; and

(c) A detailed breakdown of the unforeseeable expenses by expense line item.

(3) The department shall base its decision on whether the request clearly demonstrates that the economic or other factors that caused the expense were unexpected and arose because of conditions that could not have been anticipated by management based on their background and knowledge of nursing care industry and business trends.

(4) The department shall review the submitted information and may request additional documentation or conduct onsite visits. If an increase in costs is approved, the established rate must be adjusted upward not to exceed the limit rate.

(5) Any additional funds provided must be used to meet the unforeseeable expenses outlined in the facility's request to the department and are subject to audit. If the department determines that the funds were not used for the intended purpose, an adjustment must be made in accordance with subsection 5.

c. Adjustment to historical operating costs.

(1) A facility may receive a one-time adjustment to historical operating costs when the facility has been found to be significantly below care-related minimum standards described in subparagraph a of paragraph 2 of this subdivision and when it has been determined the facility cannot meet the minimum standards through reallocation of costs and efficiency incentives.

(2) The following conditions must be met before a facility can receive the adjustment:

(a) The facility shall document, based on nursing hours and standardized resident days, the facility cannot provide a minimum of one and two-tenths nursing hours per standardized resident day;

(b) The facility shall document all available resources, including efficiency incentives, if used to increase nursing hours, are not sufficient to meet the minimum standards; and

(c) The facility shall submit a written plan describing how the facility will meet the minimum standard if the adjustment is received, including the number and type of staff to be added to the current staff and the projected cost for salary and fringe benefits for the additional staff.

(3) The adjustment must be calculated based on the costs necessary to increase nursing hours to the minimum standards less any operating margins and incentives included when calculating the established rate. The net increase must be divided by standardized resident days and the amount calculated must be added to the rate. This rate is subject to any rate limitations that may apply.

(4) If the facility fails to implement the plan to increase nursing hours to one and two-tenths hours per standardized resident day, the amount included as the adjustment must be adjusted in accordance with the methodologies set forth in subsection 5.

(5) If the cost of implementing the plan exceeds the amount included as the adjustment, no retroactive settlement may be made.

d. Adjustments for disaster recovery costs when evacuation of residents occurs.

(1) A facility may incur certain cost when recovering from a disaster such as a flood, tornado, or fire. If evacuation of residents was necessary because of the disaster, actual recovery costs during the evacuation period, net of insurance recoveries, may be considered as deferred charges and allocated over a number of periods that benefit from the costs.

(2) When a facility has evacuated residents and capitalizes recovery costs as a deferred charge, the recovery costs must be recognized as allowable costs amortized over sixty consecutive months beginning

with the sixth month after the first resident is readmitted to the facility.

(3) Recovery costs must be identified as startup costs and included as pass-through costs for report purposes. Recovery costs are not subject to any limitations except as provided in paragraph 4.

(4) If a facility evacuates residents, the ninety percent occupancy limitation may not be applied during the recovery period or for the first six months following the month the facility readmits the first resident.

(5) Insurance recoveries relating to the disaster recovery period must be reported as a reduction of recovery costs. Insurance recoveries received after the first month of the sixty-month amortization period must be included as a reduction of deferred charges not yet amortized, except that the reduction for insurance recoveries may occur only at the beginning of a rate year.

9. Under no circumstances, including an appeal or judicial decision to the effect a rate was erroneously established, may a rate adjustment be made to any rate established under this chapter, unless the cumulative impact of all adjustments not already included in the established rate equals or exceeds five cents per day for the rate weight of one.

History: Effective September 1, 1980; amended effective July 1, 1981; December 1, 1983; July 1, 1984; September 1, 1987; January 1, 1990; April 1, 1991; January 1, 1992; November 1, 1992; November 22, 1993; January 1, 1996; January 1, 1998.
General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4; 42 USC 1396a(a)(13)

75-02-06-17. Classifications.

1. A facility shall complete a resident classification review for any resident occupying a licensed facility bed, except a respite care, hospice inpatient respite care, or hospice general care resident.

2. A resident must be classified in one of sixteen classes based on a resident classification review. If a resident classification review is not performed in accordance with subsection 3, except for a respite care, hospice inpatient respite care, or hospice general inpatient care resident, the resident must be classified as ~~special-care-B~~ reduced physical functioning C until the next required review is performed in accordance with subsection 3 for purposes of determining standardized resident days. ~~A resident, except for a respite~~

~~care,-hospice--inpatient--respite--care,--or--hospice--general inpatient--care-resident,-who-has-not-been-classified~~ and must be billed at the reduced physical functioning A established rate. A respite care, hospice inpatient respite care, or hospice general inpatient care resident who is not classified must be given a weight of one and five-tenths when determining standardized resident days.

3. Reviews must be conducted as follows:

   a. The facility shall review the resident within the first seven days after any admission or return from an acute hospital stay.

   b. The facility shall review the resident after twenty-five days, but within thirty days after any admission or return from an acute hospital stay.

   c. The facility shall review each resident twice each year. The reviews must be conducted six months apart and must be done according to a schedule established by the department for each report year.

   d. The seven-day review must take precedence over the thirty-day review and the biannual review, and the thirty-day review must take precedence over the biannual review. For example, if resident A was admitted on June first and the biannual review was in June, resident A may not be included in the June biannual review. On the other hand, if the biannual review was the second full week in July, resident A must be included, even though resident A had just had a thirty-day facility review on June thirtieth.

4. The resident classification review must be completed based on the following criteria:

   a. Assign point values for a resident's activities of daily living in the areas of:

      (1) Eating - the process of getting food by any means into the body.

      (2) Transfer - the process of moving between positions.

      (3) Toileting - all processes involved with toileting.

   b. Determine each resident's clinical group using the following hierarchy of criteria:

      (1) Heavy rehabilitation - to qualify for heavy rehabilitation, a resident must require and receive restorative physical or occupational therapy five

times per week for a minimum of two and one-half hours per week or requires and is receiving intensive bowel or bladder retraining. Residents receiving therapy separately reimbursable by a third party may not be included in this group.

(2) Special care - to qualify for special care, a resident must not qualify as heavy rehabilitation and must have an activity of daily living score of five or more and one or more of the following conditions or treatments:

(a) Stage 4 decubitus.

(b) Comatose.

(c) Suctioning.

(d) Nasal gastric feeding.

(e) Parenteral feeding.

(f) Quadriplegia.

(g) Multiple sclerosis.

(h) Ventilator dependent.

(3) Clinically complex - to qualify for clinically complex, a resident must not qualify as special care and must have one or more conditions or treatments characteristic of special care with an activity of daily living score of three or four; or must not qualify for special care and must have one or more of the following conditions or treatments:

(a) Dehydration.

(b) Internal bleeding.

(c) Stasis ulcer.

(d) Terminally ill.

(e) Daily oxygen.

(f) Wound care.

(g) Chemotherapy.

(h) Transfusion.

(i) Dialysis.

(j) Daily respiratory care.

(k) Cerebral palsy.

(l) Urinary tract infection.

(m) Hemiplegia.

(4) Special behavior - to qualify for special behavior, a resident must not qualify for clinically complex and must have one of the following conditions:

(a) Verbal disruption - level 4+.

(b) Physical aggression - level 4+.

(c) Disruptive, infantile, or socially inappropriate - level 4+.

(d) Hallucinations - level 2+.

(5) Reduced physical functioning - a resident who does not qualify for special behavior must be classified as reduced physical functioning. For a resident who has a level 4+ rating for general behavior, one point must be added to the activity of daily living score assigned in subdivision a of subsection 4.

5. Based on the resident classification review, each resident must be classified into a case-mix class with a corresponding case-mix weight as follows:

a. Heavy rehabilitation A; case-mix weight: 1.91.

b. Heavy rehabilitation B; case-mix weight: 2.24.

c. Special care A; case-mix weight: 2.45.

d. Special care B; case-mix weight: 2.67.

e. Clinically complex A; case-mix weight: 1.17.

f. Clinically complex B; case-mix weight: 1.81.

g. Clinically complex C; case-mix weight: 2.12.

h. Clinically complex D; case-mix weight: 2.63.

i. Special behavior A; case-mix weight: 1.16.

j. Special behavior B; case-mix weight: 1.48.

k. Special behavior C; case-mix weight: 1.90.

l. Reduced physical functioning A; case-mix weight: 1.00.

m. Reduced physical functioning B; case-mix weight: 1.29.

n. Reduced physical functioning C; case-mix weight: 1.48.

o. Reduced physical functioning D; case-mix weight: 1.72.

p. Reduced physical functioning E; case-mix weight: 2.21.

6. The classification is effective the date the review is completed in all cases except for the admission review. The admission review is effective the date of admission.

History: Effective September 1, 1987; amended effective January 1, 1990; November 22, 1993; January 1, 1996; January 1, 1998.
General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4; 42 USC 1396a(a)(13)

75-02-06-21. Specialized rates for extraordinary medical care.

1. A specialized rate for an individual with extraordinary medical needs may be established if the criteria in both subdivisions a and b are met.

   a. (1) The individual requires specialized therapies that are:

      (a) Restorative in nature (restorative means the individual has the ability to improve);

      (b) Medically necessary and provided in the facility;

      (c) Of at least two different types; and

      (d) Provided in excess of fifteen hours per week;

   (2) The individual requires extensive pulmonary care resulting from:

      (a) Suctioning and related tracheostomy care performed by a licensed nurse or therapist in excess of three and one-half hours in a twenty-four-hour period; or

      (b) A drug-resistant respiratory infection;

   (3) The individual requires total parenteral nutrition (TPN) and:

(a) The individual is not eligible for or has been denied medicare part A or B benefits; and

(b) The individual requires total parenteral nutrition based on medical necessity for a minimum of three months; or

(4) The individual requires the use of a ventilator and:

(a) Is dependent on the ventilator a minimum of six hours per day;

(b) Requires direct care by a licensed nurse, nurse aide, or therapist on a daily average of nine hours per day;

(c) Is physiologically stable; and

(d) Attempts to wean the individual from the ventilator have occurred during the acute hospital stay.

b. Costs to provide direct care to the individual for the specialized services must exceed two and one-half times the actual direct care rate, adjusted for inflation, prior to limitations, for the individual's resident classification, except the department may use a cost limitation of two times the actual direct care rate, if specialized equipment is purchased for use by the resident. Costs that may be included in determining if the cost factor is exceeded include salaries and fringe benefits of all direct care staff, nursing supplies, drugs, dietary supplements, and specialized equipment costs.

2. A specialized rate must be calculated for an individual who meets the criteria by subtracting the actual cost per day for direct care, prior to limitations, for the individual's classification from the total cost per day for the individual.

3. A one-time startup cost of one thousand dollars must be included in the initial specialized rate for the first thirty days after the effective date of the specialized rate.

4. ~~All~~ Except as provided for in subsection 7, all income received for a specialized rate must be offset proportionately to the affected cost categories.

5. The facility shall report costs on a monthly basis for the first three full months after admission and on a quarterly basis thereafter. The specialized rates must be adjusted to actual on a prospective basis based on the report submissions.

6. The specialized rate must be paid in addition to the rate established for the individual's resident classification.

7. If a specialized rate has been established and costs to provide direct care to the individual decrease to less than the cost limits provided for in subdivision b of subsection 1, the specialized rate must continue until the end of the rate year. Income from the specialized rate may not be offset to reported costs for the report year in which the costs to provide direct care to the individual decreased to less than the established cost limits.

History: Effective November 22, 1993; amended effective January 1, 1996; January 1, 1998.
General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4-19.2

75-02-06-22. Participation requirement. A facility must comply with the following provisions in order to be eligible to receive medical assistance payments.

1. A facility may not charge private-pay residents rates that exceed those rates approved by the department for medical assistance recipients, except that:

   a. A facility may charge a higher rate for a private room.

   b. A facility may charge for special services not included in the daily rate if medical assistance residents are charged separately at the same rate for the same services. Special services must be available to all residents and residents must be free to select or decline the special services. Special services may not include services provided by the facility in order to comply with licensure or certification standards which, if not provided, would result in a deficiency or violation by the facility. Services beyond those required to comply with licensure or certification standards may not be charged separately as special services if the services were included as allowable costs used to establish the current established rate. Special services may include cable television, telephones, long-distance calls, nonroutine hair care such as permanents requested by a resident, and the additional cost of brand name supplies requested by a resident and not ordinarily stocked. A facility shall inform the resident or a person acting on behalf of the resident that a charge may be made and the amount of the charge at the time a request for the special services is made.

   c. A facility may charge to hold a bed for a period in excess of the periods covered by subsections 3, 4, and 5, and 6 of section 75-02-06-14 if:

(1) The resident, or a person acting on behalf of the resident, has requested the bed be held and the facility informs the person making the request, at the time of the request, of the amount of the charge;

(2) For a medical assistance resident, the payment comes from sources other than from the resident's monthly income; and

(3) All residents are charged the same amount.

d. A facility may charge for medicare part A and part B coinsurance and deductibles.

2. A facility may not require, as a condition of admission, any applicant to pay a fee or a deposit, loan any money to the facility, or promise to leave all or part of the applicant's estate to the facility.

3. A facility may not require any resident to use a vendor of health care services who is a licensed physician or pharmacist chosen by the facility.

4. A facility may not provide differential treatment on the basis of status with regard to public assistance.

5. A facility may not discriminate in admission, services offered, or room assignment on the basis of status with regard to medical assistance. The collection and use by a facility of financial information of any applicant pursuant to a preadmission screening program does not raise an inference that the facility is using that information for any purpose prohibited by this chapter. Admission discrimination includes:

a. Basing admission decisions upon an assurance by the applicant to the facility, or the applicant's guardian or conservator, that the applicant is neither eligible for nor will seek medical assistance for payment of facility care costs; or

b. Engaging in preferential selection from waiting lists based on an applicant's ability to pay privately.

6. A facility may not require any vendor of medical care, who is reimbursed by medical assistance under a separate fee schedule, to pay any portion of the fee to the facility except as payment for the fair market value of renting or leasing space or equipment of the facility or purchasing support services, if those agreements are disclosed to the department.

7. A facility may not refuse, for more than twenty-four hours, to accept a resident returning to the same bed or an available

bed certified for the same level of care, in accordance with a physician's order authorizing transfer, after receiving inpatient hospital services.

8. A facility may not violate any rights of a health care facility resident as set forth in North Dakota Century Code section 50-10.2-02.

9. Any facility certified as a nursing facility shall participate in medicare part A and part B with respect to at least thirty percent of the beds in the facility.

10. If medicare covered services are provided to a resident who is simultaneously eligible for medical assistance and medicare, the facility shall bill for medicare part A and part B before billing medical assistance. The department may be billed only for charges not payable by medicare. Medicare part B covered services are not included in the daily rate.

11. A facility shall file on behalf of each resident or assist each resident in filing requests for any third-party benefits to which the resident may be entitled.

12. A facility shall be certified to participate in the medical assistance program and have a provider agreement with the department.

13. If a facility does not comply with the provisions of this section, the department may continue, if extreme hardship to the residents would otherwise result, to make medical assistance payments to the facility for a period not to exceed one hundred eighty days from the date of mailing a formal notice. In these cases, the department shall issue an order requiring the facility to correct the violation. If the violation is not corrected within the twenty-day period, the department may reduce the payment rate to the facility by up to twenty percent. The amount of the payment rate reduction must be related to the severity of the violation, and must remain in effect until the violation is corrected. The facility may seek reconsideration of or appeal the department's action as provided for in section 75-02-06-25.

14. A facility may charge a higher rate for a private room used by a medical assistance resident if:

    a. The private room is not medically necessary;

    b. The resident, or a person acting on behalf of the resident, has requested the private room and the facility informs the person making the request, at the time of the request, of the amount of the payment and that the payment must come from sources other than a resident's monthly income; and

c. The payment does not exceed the amount charged to private-pay residents.

15. A facility may not accept any payment to hold a bed prior to the admission of a resident.

16. A facility shall readmit a resident whose leave exceeds the facility's bed hold period upon the first availability of a bed in a semiprivate room if the resident:

a. Requires the services provided by the facility; and

b. Is eligible for medical assistance.

History: Effective January 1, 1996; amended effective January 1, 1998.
General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4; 42 USC 1396a(a)(13)

75-02-06-26. Reconsiderations and appeals.

1. **Reconsiderations.**

a. Any requests for reconsideration of the final rate must be filed with the department's medical services division within thirty days of the date of the rate notification.

b. A request for reconsideration must include:

(1) A statement of each disputed item and the reason or basis for the dispute;

(2) The dollar amount of each adjustment that is disputed; and

(3) The authority in statute or rule upon which the facility is relying for each disputed item.

c. The department may request additional documentation or information relating to a disputed item. If additional documentation is not provided within fourteen days of the department's request, the department shall make its determination based on the information and documentation available as of the fourteenth day following the date the department requested additional documentation.

d. The department's medical services division shall make a determination regarding the reconsideration within forty-five days of receiving the reconsideration filing and any requested documentation.

2. **Appeals.** A provider dissatisfied with the final rate established may appeal upon completion of the reconsideration

process as provided for in subsection 1. An appeal may be perfected by mailing or delivering, on or before five p.m. on the thirty-first day after the date of mailing of the determination of the medical services division made with respect to a request for reconsideration, the information described in subdivisions a through e to the department, at the address the department designates. An appeal under this section is perfected only if accompanied by written documents including:

a. A copy of the letter received from the medical services division advising of that division's decision on the request for reconsideration;

b. A statement of each disputed item and the reason or basis for the dispute;

c. A computation and the dollar amount that reflects the appealing party's claim as to the correct computation and dollar amount for each disputed item;

d. The authority in statute or rule upon which the appealing party relies for each disputed item; and

e. The name, address, and telephone number of the person to whom all notices regarding the appeal may be sent.

History: Effective January 1, 1996; amended effective January 1, 1998.
General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4; 42 USC 1396a(a)(13)

TITLE 92

Workers Compensation Bureau

DECEMBER 1997

CHAPTER 92-01-02

92-01-02-53. Workers compensation bureau scholarship fund - Application criteria - Refund. An applicant for a workers' compensation scholarship offered under North Dakota Century Code section 65-05-20.1 must complete the application form required by the bureau. The scholarship committee will use the information on the application form to determine which applicants receive the scholarship. The minimum required grade point average is a two point zero on a four point zero scale, or its equivalent. If there are insufficient funds to award full scholarships to all qualified applicants, the scholarship committee shall award the scholarships based on the financial need of the applicants and the bureau may award individual scholarships in any amount up to one thousand five hundred dollars per year. Applicants who are awarded the scholarship one year must reapply to receive the scholarship in a subsequent year. If the amount awarded to the applicant is greater than the amount owed the institution over the course of the school year, the excess award must be refunded to the bureau. If the applicant who is awarded a scholarship withdraws from the institution and there are scholarship funds to be refunded, the institution shall refund those funds to the bureau according to the refund priorities of the institution.

History: Effective December 1, 1997.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-05-20.1