State of Minnesota

HOUSE OF REPRESENTATIVES

EIGHTY-EIGHTH SESSION

H. F. No. 2916

03/10/2014 Authored by Liebling
The bill was read for the first time and referred to the Committee on Health and Human Services Policy

A bill for an act

relating to human services; modifying provisions related to human services operations and health care; modifying bond requirements for medical suppliers; repealing certain reports and obsolete rules; authorizing rulemaking; requiring the commissioner to seek federal authority to amend the state Medicaid plan; making technical changes; amending Minnesota Statutes 2012, sections 256B.5016, subdivision 1; 256B.69, subdivision 16; 393.01, subdivisions 2, 7; Minnesota Statutes 2013 Supplement, section 256B.04, subdivision 21; Laws 2011, First Special Session chapter 9, article 9, section 17; repealing Minnesota Statutes 2012, section 256.01, subdivision 32; Minnesota Rules, parts 9500.1126; 9500.1450, subpart 3; 9500.1452, subpart 3; 9500.1456; 9505.5300; 9505.5305; 9505.5310; 9505.5315; 9505.5325; 9525.1580.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2013 Supplement, section 256B.04, subdivision 21, is amended to read:

Subd. 21. **Provider enrollment.** (a) If the commissioner or the Centers for Medicare and Medicaid Services determines that a provider is designated "high-risk," the commissioner may withhold payment from providers within that category upon initial enrollment for a 90-day period. The withholding for each provider must begin on the date of the first submission of a claim.

(b) An enrolled provider that is also licensed by the commissioner under chapter 245A must designate an individual as the entity's compliance officer. The compliance officer must:

(1) develop policies and procedures to assure adherence to medical assistance laws and regulations and to prevent inappropriate claims submissions;

(2) train the employees of the provider entity, and any agents or subcontractors of the provider entity including billers, on the policies and procedures under clause (1);

(3) respond to allegations of improper conduct related to the provision or billing of medical assistance services, and implement action to remediate any resulting problems;

(4) use evaluation techniques to monitor compliance with medical assistance laws and regulations;

(5) promptly report to the commissioner any identified violations of medical assistance laws or regulations; and

(6) within 60 days of discovery by the provider of a medical assistance reimbursement overpayment, report the overpayment to the commissioner and make arrangements with the commissioner for the commissioner's recovery of the overpayment.

The commissioner may require, as a condition of enrollment in medical assistance, that a provider within a particular industry sector or category establish a compliance program that contains the core elements established by the Centers for Medicare and Medicaid Services.

(c) The commissioner may revoke the enrollment of an ordering or rendering provider for a period of not more than one year, if the provider fails to maintain and, upon request from the commissioner, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by such provider, when the commissioner has identified a pattern of a lack of documentation. A pattern means a failure to maintain documentation or provide access to documentation on more than one occasion. Nothing in this paragraph limits the authority of the commissioner to sanction a provider under the provisions of section 256B.064.

(d) The commissioner shall terminate or deny the enrollment of any individual or entity if the individual or entity has been terminated from participation in Medicare or under the Medicaid program or Children's Health Insurance Program of any other state.

(e) As a condition of enrollment in medical assistance, the commissioner shall require that a provider designated "moderate" or "high-risk" by the Centers for Medicare and Medicaid Services or the commissioner permit the Centers for Medicare and Medicaid Services, its agents, or its designated contractors and the state agency, its agents, or its designated contractors to conduct unannounced on-site inspections of any provider location. The commissioner shall publish in the Minnesota Health Care Program Provider Manual a list of provider types designated "limited," "moderate," or "high-risk," based on the criteria and standards used to designate Medicare providers in Code of Federal Regulations, title 42, section 424.518. The list and criteria are not subject to the requirements of chapter 14. The commissioner's designations are not subject to administrative appeal.

(f) As a condition of enrollment in medical assistance, the commissioner shall require that a high-risk provider, or a person with a direct or indirect ownership interest in

the provider of five percent or higher, consent to criminal background checks, including fingerprinting, when required to do so under state law or by a determination by the commissioner or the Centers for Medicare and Medicaid Services that a provider is designated high-risk for fraud, waste, or abuse.

(g)(1) Upon initial enrollment, reenrollment, and notification of revalidation, all durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers operating in Minnesota and receiving Medicaid funds must purchase a surety bond that is annually renewed and designates the Minnesota Department of Human Services as the obligee, and must be submitted in a form approved by the commissioner. A medical supplier subject to the surety bond requirement in this clause is limited to a provider enrolled or eligible for enrollment as provider type 76. For purposes of this clause, the following providers are not medical suppliers and are not required to obtain a surety bond: a federally qualified health center, a home health agency, the Indian Health Service, a pharmacy, and a rural health clinic.

(2) At the time of initial enrollment or reenrollment, ~~the provider agency~~ all medical suppliers enrolled as provider type 76 must purchase a performance bond of $50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is up to and including $300,000, the provider agency must purchase a performance bond of $50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is over $300,000, the provider agency must purchase a performance bond of $100,000. The performance bond must allow for recovery of costs and fees in pursuing a claim on the bond.

(3) For purposes of clauses (1) and (2), "provider type 76" means a medical supplier that can purchase medical equipment or supplies for sale or rental to the general public and is able to perform or arrange for necessary repairs to and maintenance of equipment offered for sale or rental.

(h) The Department of Human Services may require a provider to purchase a performance surety bond as a condition of initial enrollment, reenrollment, reinstatement, or continued enrollment if: (1) the provider fails to demonstrate financial viability, (2) the department determines there is significant evidence of or potential for fraud and abuse by the provider, or (3) the provider or category of providers is designated high-risk pursuant to paragraph (a) and as per Code of Federal Regulations, title 42, section 455.450. The performance bond must be in an amount of $100,000 or ten percent of the provider's payments from Medicaid during the immediately preceding 12 months, whichever is greater. The performance bond must name the Department of Human Services as an obligee and must allow for recovery of costs and fees in pursuing a claim on the bond.

Sec. 2. Minnesota Statutes 2012, section 256B.5016, subdivision 1, is amended to read:

Subdivision 1. **Managed care pilot.** The commissioner may initiate a capitated risk-based managed care option for services in an intermediate care facility for persons with developmental disabilities according to the terms and conditions of the federal agreement governing the managed care pilot. The commissioner may grant a variance to any of the provisions in sections 256B.501 to 256B.5015 and Minnesota Rules, parts 9525.1200 to 9525.1330 ~~and 9525.1580~~.

Sec. 3. Minnesota Statutes 2012, section 256B.69, subdivision 16, is amended to read:

Subd. 16. **Project extension.** Minnesota Rules, parts 9500.1450; 9500.1451; 9500.1452; 9500.1453; 9500.1454; 9500.1455; ~~9500.1456;~~ 9500.1457; 9500.1458; 9500.1459; 9500.1460; 9500.1461; 9500.1462; 9500.1463; and 9500.1464 are extended.

Sec. 4. Minnesota Statutes 2012, section 393.01, subdivision 2, is amended to read:

Subd. 2. **Selection of members, terms, vacancies.** Except in counties which contain a city of the first class and counties having a poor and hospital commission, the local social services agency shall consist of seven members, including the board of county commissioners, to be selected as herein provided; two members, one of whom shall be a woman, shall be appointed by the ~~commissioner of human services~~ board of county commissioners, one each year for a full term of two years, from a list of residents~~, submitted by the board of county commissioners~~. As each term expires or a vacancy occurs by reason of death or resignation, a successor shall be appointed by the ~~commissioner of human services~~ board of county commissioners for the full term of two years or the balance of any unexpired term from a list of one or more, not to exceed three residents ~~submitted by the board of county commissioners~~. The board of county commissioners may, by resolution adopted by a majority of the board, determine that only three of their members shall be members of the local social services agency, in which event the local social services agency shall consist of five members instead of seven. When a vacancy occurs on the local social services agency by reason of the death, resignation, or expiration of the term of office of a member of the board of county commissioners, the unexpired term of such member shall be filled by appointment by the county commissioners. Except to fill a vacancy the term of office of each member of the local social services agency shall commence on the first Thursday after the first Monday in July, and continue until the expiration of the term for which such member was appointed or until a successor is appointed and qualifies. ~~If the board of county commissioners shall refuse, fail, omit, or neglect to submit one or more nominees to the commissioner of human services for appointment to the local~~

~~social services agency by the commissioner of human services, as herein provided, or to appoint the three members to the local social services agency, as herein provided, by the time when the terms of such members commence, or, in the event of vacancies, for a period of 30 days thereafter, the commissioner of human services is hereby empowered to and shall forthwith appoint residents of the county to the local social services agency. The commissioner of human services, on refusing to appoint a nominee from the list of nominees submitted by the board of county commissioners, shall notify the county board of such refusal. The county board shall thereupon nominate additional nominees. Before the commissioner of human services shall fill any vacancy hereunder resulting from the failure or refusal of the board of county commissioners of any county to act, as required herein, the commissioner of human services shall mail 15 days' written notice to the board of county commissioners of its intention to fill such vacancy or vacancies unless the board of county commissioners shall act before the expiration of the 15-day period.~~

Sec. 5. Minnesota Statutes 2012, section 393.01, subdivision 7, is amended to read:

Subd. 7. **Joint exercise of powers.** Notwithstanding the provisions of subdivision 1 two or more counties may by resolution of their respective boards of county commissioners, agree to combine the functions of their separate local social services agency into one local social services agency to serve the two or more counties that enter into the agreement. Such agreement may be for a definite term or until terminated in accordance with its terms. When two or more counties have agreed to combine the functions of their separate local social services agency, a single local social services agency in lieu of existing individual local social services agency shall be established to direct the activities of the combined agency. This agency shall have the same powers, duties and functions as an individual local social services agency. The single local social services agency shall have representation from each of the participating counties with selection of the members to be as follows:

(a) Each board of county commissioners entering into the agreement shall on an annual basis select one or two of its members to serve on the single local social services agency.

(b) Each board of county commissioners entering into the agreement shall ~~in accordance with procedures established by the commissioner of human services, submit a list of names of three county residents, who shall not be county commissioners, to the commissioner of human services. The commissioner shall~~ select one ~~person from each county list~~ county resident who is not a county commissioner to serve as a local social services agency member.

(c) The composition of the agency may be determined by the boards of county commissioners entering into the agreement providing that no less than one-third of the members are appointed as provided in clause (b).

Sec. 6. Laws 2011, First Special Session chapter 9, article 9, section 17, is amended to read:

Sec. 17. **SIMPLIFICATION OF ELIGIBILITY AND ENROLLMENT PROCESS.**

(a) The commissioner of human services shall issue a request for information for an integrated service delivery system for health care programs, food support, cash assistance, and child care. The commissioner shall determine, in consultation with partners in paragraph (c), if the products meet departments' and counties' functions. The request for information may incorporate a performance-based vendor financing option in which the vendor shares the risk of the project's success. The health care system must be developed in phases with the capacity to integrate food support, cash assistance, and child care programs as funds are available. The request for information must require that the system:

(1) streamline eligibility determinations and case processing to support statewide eligibility processing;

(2) enable interested persons to determine eligibility for each program, and to apply for programs online in a manner that the applicant will be asked only those questions relevant to the programs for which the person is applying;

(3) leverage technology that has been operational in other state environments with similar requirements; and

(4) include Web-based application, worker application processing support, and the opportunity for expansion.

(b) The commissioner shall issue a final report, including the implementation plan, to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services no later than January 31, 2012.

(c) The commissioner shall partner with counties, a service delivery authority established under Minnesota Statutes, chapter 402A, the Office of Enterprise Technology, other state agencies, and service partners to develop an integrated service delivery framework, which will simplify and streamline human services eligibility and enrollment processes. The primary objectives for the simplification effort include significantly improved eligibility processing productivity resulting in reduced time for eligibility determination and enrollment, increased customer service for applicants and recipients of services, increased program integrity, and greater administrative flexibility.

(d) ~~The commissioner, along with a county representative appointed by the Association of Minnesota Counties, shall report specific implementation progress to the legislature annually beginning May 15, 2012.~~

~~(e)~~ The commissioner shall work with the Minnesota Association of County Social Service Administrators and the Office of Enterprise Technology to develop collaborative task forces, as necessary, to support implementation of the service delivery components under this paragraph. The commissioner must evaluate, develop, and include as part of the integrated eligibility and enrollment service delivery framework, the following minimum components:

(1) screening tools for applicants to determine potential eligibility as part of an online application process;

(2) the capacity to use databases to electronically verify application and renewal data as required by law;

(3) online accounts accessible by applicants and enrollees;

(4) an interactive voice response system, available statewide, that provides case information for applicants, enrollees, and authorized third parties;

(5) an electronic document management system that provides electronic transfer of all documents required for eligibility and enrollment processes; and

(6) a centralized customer contact center that applicants, enrollees, and authorized third parties can use statewide to receive program information, application assistance, and case information, report changes, make cost-sharing payments, and conduct other eligibility and enrollment transactions.

~~(f)~~ (e) Subject to a legislative appropriation, the commissioner of human services shall issue a request for proposal for the appropriate phase of an integrated service delivery system for health care programs, food support, cash assistance, and child care.

Sec. 7. **RULEMAKING; REDUNDANT PROVISION REGARDING TRANSITION LENSES.**

The commissioner of human services shall amend Minnesota Rules, part 9505.0277, subpart 3, to remove transition lenses from the list of eyeglass services not eligible for payment under the medical assistance program. The commissioner may use the good cause exemption in Minnesota Statutes, section 14.388, subdivision 1, clause (4), to adopt rules under this section. Minnesota Statutes, section 14.386, does not apply except as provided in Minnesota Statutes, section 14.388.

Sec. 8. **FEDERAL APPROVAL.**

By October 1, 2015, the commissioner of human services shall seek federal authority to operate the program in Minnesota Statutes, section 256B.78, under the state Medicaid plan, in accordance with United States Code, title 42, section 1396a(a)(10)(A)(ii)(XXI). To be eligible, an individual must have family income at or below 200 percent of the federal poverty guidelines, except that for an individual under age 21, only the income of the individual must be considered in determining eligibility. Services under this program must be available on a presumptive eligibility basis.

Sec. 9. **REVISOR'S INSTRUCTION.**

The revisor of statutes shall remove cross-references to the sections and parts repealed in section 10, paragraphs (a) and (b), wherever they appear in Minnesota Rules and shall make changes necessary to correct the punctuation, grammar, or structure of the remaining text and preserve its meaning.

Sec. 10. **REPEALER.**

(a) Minnesota Statutes 2012, section 256.01, subdivision 32, is repealed.

(b) Minnesota Rules, parts 9500.1126; 9500.1450, subpart 3; 9500.1452, subpart 3; 9500.1456; and 9525.1580, are repealed.

(c) Minnesota Rules, parts 9505.5300; 9505.5305; 9505.5310; 9505.5315; and 9505.5325, are repealed contingent upon federal approval of the state Medicaid plan amendment under section 8. The commissioner of human services shall notify the revisor of statutes when this occurs.

256.01 COMMISSIONER OF HUMAN SERVICES; POWERS, DUTIES.

Subd. 32. **Review and evaluation of ongoing studies.** The commissioner shall review all ongoing studies, reports, and program evaluations completed by the Department of Human Services for state fiscal years 2006 through 2010. For each item, the commissioner shall report the legislature's appropriation for that work, if any, and the actual reported cost of the completed work by the Department of Human Services. The commissioner shall make recommendations to the legislature about which studies, reports, and program evaluations required by law on an ongoing basis are duplicative, unnecessary, or obsolete. The commissioner shall repeat this review every five fiscal years.

9500.1126 RECAPTURE OF DEPRECIATION.

Subpart 1. **Recapture of depreciation.** The commissioner shall determine the recapture of depreciation due to a change in the ownership of a hospital that is to be apportioned to medical assistance, using methods and principles consistent with those used by medicare to determine and apportion the recapture of depreciation.

Subp. 2. **Payment of recapture of depreciation to commissioner.** A hospital shall pay the commissioner the recapture of depreciation within 60 days of written notification from the commissioner.

Interest charges must be assessed on the recapture of depreciation due the commissioner outstanding after the deadline. The annual interest rate charged must be the rate charged by the commissioner of revenue for late payment of taxes in effect on the 61st day after the written notification.

9500.1450 INTRODUCTION.

Subp. 3. **Geographic area.** PMAP shall be operated in the counties of Dakota, Hennepin, and Itasca and other geographical areas designated by the commissioner. If the geographic area is expanded beyond Dakota, Hennepin, and Itasca Counties, participating counties in the expanded area shall receive at least 180 days notice from the commissioner before implementation of PMAP and shall be governed by parts 9500.1450 to 9500.1464.

9500.1452 ELIGIBILITY TO ENROLL IN A HEALTH PLAN.

Subp. 3. **Exclusions during phase-in period.** The 65 percent of medical assistance eligible persons in Hennepin County who were not randomly selected to participate in the former medical assistance prepaid demonstration project because they served as a control group must participate in PMAP. Hennepin County may temporarily exclude individuals' participation in PMAP in order to provide an orderly phase-in period for new enrollees. The phase-in period must be completed within one year from the start of the enrollment period for each category of eligible PMAP consumers.

Counties participating in the prepaid medical assistance program for the first time after June 30, 1991, may temporarily exclude PMAP consumers from participation in PMAP in order to provide an orderly phase-in period for new enrollees. The phase-in period must be completed within one year from the start of the enrollment period for each category of eligible PMAP consumers.

9500.1456 IDENTIFICATION OF ENROLLEES.

A MHP shall identify enrollees in a way convenient to its normal operational procedures.

9505.5300 APPLICABILITY.

Parts 9505.5300 to 9505.5325 govern the Minnesota Family Planning Program Section 1115 Demonstration Project. The demonstration project is a Medicaid waiver demonstration project approved by the Centers for Medicare and Medicaid Services to provide federally approved contraception management services to eligible low-income persons.

9505.5305 DEFINITIONS.

Subpart 1. **Scope.** The terms used in parts 9505.5300 to 9505.5325 have the meanings given them in this part.

Subp. 2. **Applicant.** "Applicant" means a person who submits a written demonstration project application to the department for a determination of eligibility for the demonstration project.

Subp. 3. **Certified family planning services provider.** "Certified family planning services provider" means a family planning services provider that meets the requirements of part 9505.5315, subpart 1.

Subp. 4. **Commissioner.** "Commissioner" means the commissioner of human services or the commissioner's designee.

Subp. 5. **Contraception management services.** "Contraception management services" means a scope of family planning services limited to initiating or obtaining an enrollee's contraceptive method and maintaining effective use of that method.

Subp. 6. **Countable income.** "Countable income" means the income, including deemed income, used to determine a person's eligibility for the demonstration project.

Subp. 7. **County agency.** "County agency" has the meaning given in Minnesota Statutes, section 256B.02, subdivision 6.

Subp. 8. **Demonstration project.** "Demonstration project" means the Minnesota Family Planning Program Section 1115 Demonstration Project, Project Number 11-W-00183/5.

Subp. 9. **Department.** "Department" means the Minnesota Department of Human Services.

Subp. 10. **Enrollee.** "Enrollee" means a person enrolled in the demonstration project.

Subp. 11. **Family planning services provider.** "Family planning services provider" includes the providers listed in part 9505.0280, subpart 3, and clinical nurse specialists, laboratories, ambulatory surgical centers, federally qualified health centers, Indian Health Services, public health nursing clinics, and physician assistants who are authorized providers under part 9505.0195.

Subp. 12. **Family size.** "Family size" means the number of people used to determine a person's income standard. The family size includes the person and the following people who live with the person: the person's spouse, the biological and adoptive children of the person who are under age 21, and the biological and adoptive children of the person's spouse who are under age 21.

Subp. 13. **Minnesota health care program.** "Minnesota health care program" means medical assistance under Minnesota Statutes, chapter 256B, general assistance medical care under Minnesota Statutes, section 256D.03, and MinnesotaCare under Minnesota Statutes, chapter 256L.

Subp. 14. **Presumptive eligibility.** "Presumptive eligibility" means the temporary period of eligibility for the demonstration project that is determined at the point of service by a certified family planning services provider.

Subp. 15. **Qualified noncitizen eligible for medical assistance with federal financial participation.** "Qualified noncitizen eligible for medical assistance with federal financial participation" means a person that meets the requirements of Minnesota Statutes, section 256B.06, subdivision 4.

Subp. 16. **Resident.** "Resident" means a person who meets the requirements in part 9505.0030.

9505.5310 DEMONSTRATION PROJECT ELIGIBILITY, APPLICATION, ENROLLMENT, AND DOCUMENTATION.

Subpart 1. **General eligibility.** The eligibility and coverage requirements in this subpart apply to applicants and enrollees.

A. Except as provided in subpart 2, an applicant or enrollee must meet the following requirements to be eligible for the demonstration project:

(1) be a citizen of the United States or a qualified noncitizen eligible for medical assistance with federal financial participation;

(2) be a Minnesota resident;

(3) be 15 years of age or older and under age 50;

(4) have countable income at or below 200 percent of the federal poverty guidelines for the family size. Countable income is determined according to the income rules applied in eligibility determinations for families and children in the medical assistance program according to Minnesota Statutes, section 256B.056, and United States Code, title 42, chapter 7, subchapter XIX, section 1396u-1, as follows:

(a) income includes all categories of earned and unearned income used in eligibility determinations for families and children under the medical assistance program;

(b) income does not include any categories of income that are excluded for purposes of determining eligibility for families and children in the medical assistance program;

(c) income methodologies, such as earned income deductions and disregards, used to determine eligibility for families and children in the medical assistance program according to Minnesota Statutes, section 256B.056, subdivisions 1a and 1c, do not apply to the determination of countable income; and

(d) income deeming requirements used to determine eligibility for families and children in the medical assistance program apply, except that for a person under age 21, no income from a parent, spouse, or sponsor is deemed to the person;

(5) not be pregnant;

(6) not be enrolled in the Minnesota health care program or other health service program administered by the department; and

(7) not be an institutionalized individual as described under Code of Federal Regulations, title 42, sections 435.1008 and 435.1009.

B. Participation in the demonstration project does not require the consent of anyone other than the applicant.

C. Asset requirements do not apply to applicants and enrollees.

D. Applicants and enrollees must report available third-party coverage and cooperate with the department in obtaining third-party payments. The department shall waive this requirement if the applicant or enrollee states that reporting third-party coverage could violate the applicant's or enrollee's privacy.

Subp. 2. **Presumptive eligibility.** Services covered under the demonstration project may be provided during a presumptive eligibility period.

A. A certified family planning services provider will screen a person for demonstration project eligibility using preliminary information provided by the person. A person who, based on the preliminary information, appears to meet the eligibility requirements in part 9505.5310, subpart 1, item A, subitems (2) to (6), is presumptively eligible for the demonstration project.

B. The presumptive eligibility period begins the first day of the month that a certified family planning services provider determines that a person is presumptively eligible. The presumptive eligibility period ends the last day of the month following the month that the certified family planning services provider determines that a person was presumptively eligible.

C. A person determined presumptively eligible must comply with part 9505.5310, subpart 1, item D.

D. A person may receive presumptive eligibility once during a 12-month period.

Subp. 3. **Enrollment.** An applicant must apply for the demonstration project using forms provided by the department.

A. The department or county agency must determine an applicant's eligibility for the demonstration project within 45 days of receipt of a completed application.

B. Except as provided in item C, eligibility begins the first day of the month of application. If a completed application form is submitted within 30 days of the request, the month of application includes the month the department or county agency receives a written request for the demonstration project consisting of at least the name of the applicant, a means to locate the applicant, and the signature of the applicant.

C. A person who is eligible under subparts 1 and 2 and files a demonstration project application during the presumptive eligibility period is eligible for ongoing coverage on the first day of the month following the month that presumptive eligibility ends.

Subp. 4. **Application and documentation.** The application and documentation requirements in this subpart apply to all applicants and enrollees.

A. An enrollee is eligible for the demonstration project for one year regardless of changes in income or family size. Eligibility will end prior to the annual renewal if the enrollee:

(1) dies;

(2) is no longer a Minnesota resident;

(3) voluntarily terminates eligibility;

(4) enrolls in the Minnesota health care program or other health service program administered by the department;

(5) reaches 50 years of age;

(6) becomes pregnant;

(7) becomes an institutionalized individual under Code of Federal Regulations, title 42, sections 435.1008 and 435.1009; or

(8) is no longer a citizen of the United States or a qualified noncitizen eligible for medical assistance with federal financial participation.

B. Applicants and enrollees must document their income at application.

C. Enrollees must complete an annual application on forms provided by the department.

D. Applicants and enrollees must provide documentation of immigration status at application. The department or county agency will verify applicant and enrollee immigration status according to Minnesota Statutes, section 256.01, subdivision 18.

E. Applicants and enrollees must report a change in an eligibility factor to the department or county agency within ten days of learning about the change. Applicants and enrollees who fail to report a change that would have resulted in ineligibility for the demonstration project will be disenrolled from the demonstration project and will be ineligible for the demonstration project for a period of 12 months following the date of disenrollment. If the only unreported change is a pregnancy, applicants and enrollees will not be subject to the 12 months ineligibility period, but pregnant applicants and enrollees will be disenrolled from the demonstration project and may reapply for the demonstration project following the end of the pregnancy.

F. Applicants and enrollees must provide information, documents, and any releases requested by the department or county agency that are necessary to verify eligibility information. An applicant or enrollee who refuses to authorize verification of an eligibility factor, including a Social Security number, is not eligible for the demonstration project, except as provided in Code of Federal Regulations, title 42, section 435.910(h)(2).

G. Applicants must document citizenship as required by the federal Deficit Reduction Act of 2005, Public Law 109-71. Persons screened for presumptive eligibility under subpart 2 are not required to document citizenship.

H. An applicant may withdraw an application according to the provisions of part 9505.0090, subpart 4.

Subp. 5. **Enrollment.** To be considered for Minnesota health care program eligibility, an enrollee must complete the department's health care application. Applicants and enrollees shall not use a demonstration project application form to apply for the Minnesota health care program. People who complete the department's health care application and are determined ineligible for the Minnesota health care program, either at application or during enrollment, may authorize a demonstration project eligibility determination using the information provided in the department's health care application and updated at required intervals.

Subp. 6. **Confidentiality.** Private data about persons screened for eligibility, applicants, and enrollees must be disclosed according to the provisions of the following statutes and rules:

A. part 1205.0500 and Minnesota Statutes, chapter 13;

B. Minnesota Statutes, sections 144.291 to 144.298;

C. Minnesota Statutes, section 144.343;

D. Code of Federal Regulations, title 45, parts 160, 162, and 164; and

E. other applicable state and federal laws, statutes, rules, and regulations affecting the collection, storage, use, and dissemination of protected, private, and confidential health and other information.

Subp. 7. **Notices.** Applicants and enrollees may arrange to receive notices in a manner other than having notices mailed to the applicant's or enrollee's home address.

9505.5315 PROVIDERS OF FAMILY PLANNING SERVICES.

Subpart 1. **Certified family planning services provider requirements.** To become a certified family planning services provider, a family planning services provider must:

A. sign the business associate agreement;

B. complete required training;

C. provide information about presumptive eligibility to interested persons;

D. help interested persons complete demonstration project applications and forms;

E. use the department's eligibility verification system to verify a person screened for demonstration project eligibility does not receive Minnesota health care program coverage;

F. determine presumptive eligibility;

G. give required notices to a person screened for eligibility;

H. promptly forward completed applications and forms to the department; and

I. cooperate with department application tracking and program evaluation activities.

Subp. 2. **Covered services.** The demonstration project covers contraception management services and certain additional medical diagnosis or treatment services that are provided within the context of a visit for contraception management services. All services covered by the demonstration project are listed in Attachment B of the Centers for Medicare and Medicaid Services Special Terms and Conditions for the Minnesota Family Planning Program Section 1115 Demonstration, Project Number 11-W-00183/5 and its amendments, which are incorporated by reference. This document can be found at the Minnesota Law Library, Judicial Center, 25

Rev. Dr. Martin Luther King Jr. Blvd., Saint Paul, Minnesota 55155. Attachment B is subject to frequent change.

Subp. 3. **Payment for services.** Family planning services providers are paid for covered services as follows:

A. No cost-sharing requirements apply to services provided under the demonstration project.

B. Payments will be made on a fee-for-service basis to providers for services provided under the demonstration project.

C. All covered services provided during the presumptive eligibility period according to part 9505.5310, subpart 2, will be reimbursed.

D. The demonstration project is the payer of last resort. The demonstration project will not cover drugs that are covered under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible for drug coverage as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A).

E. Parts 9505.2160 to 9505.2245, regarding surveillance and integrity review, apply to services provided under parts 9505.5300 to 9505.5325.

9505.5325 APPEALS.

Subpart 1. **Notice.** The commissioner must follow the notification procedures in part 9505.0125 if the commissioner denies, suspends, reduces, or terminates eligibility or covered health services, except as provided in subpart 3.

Subp. 2. **Appeal process.** A person aggrieved by a determination or action of the commissioner under parts 9505.5300 to 9505.5325 may appeal the department's or county agency's determination or action according to Minnesota Statutes, section 256.045, except as provided in subpart 3.

Subp. 3. **Denial of presumptive eligibility.** There is no right of appeal for a denial of presumptive eligibility.

9525.1580 CONTROL AND LOCATION OF SERVICES.

Subpart 1. **Definitions.** The terms used in subparts 2 and 3 have the meanings given them in this subpart.

A. "Related legal entities" means entities that share any governing board members or an executive director or are owned or partially owned by the same individual or individuals, or by related individuals.

B. "Related individuals" means individuals whose relationship to each other by blood, marriage, or adoption is not more remote than first cousin.

Subp. 2. **Control of services.** Training and habilitation services licensed under Minnesota Statutes, chapter 245B and licensed residential services must not be provided to the same person by related legal entities. This requirement does not apply:

A. to residential and day habilitation services directly administered by a county board or by the commissioner at a regional center;

B. to residential and day habilitation services offered by a training and habilitation services provider licensed before April 15, 1983; or

C. to services provided to a person who resides at home with the person's family or foster family and who is receiving a combination of day habilitation and residential based habilitation services under parts 9525.1800 to 9525.1930.

Subp. 3. **Location of services.** Training and habilitation services must be provided away from the residence of the person receiving services in communities where the person lives and works.