CHAPTER 256B

MEDICAL ASSISTANCE FOR NEEDY PERSONS

256B.039 REPORTING OF SUPPLEMENTAL NURSING SERVICES AGENCY USE.

Beginning March 1, 2002, the commissioner shall report to the legislature annually on the use of supplemental nursing services, including the number of hours worked by supplemental nursing services agency personnel and payments to supplemental nursing services agencies.

History: *1Sp2001 c 9 art 7 s 7*

256B.04 DUTIES OF STATE AGENCY.

[For text of subds 1 and 1a, see M.S.2000]

Subd. 1b. **Contract for administrative services for American Indian children.** Notwithstanding subdivision 1, the commissioner may contract with federally recognized Indian tribes with a reservation in Minnesota for the provision of early and periodic screening, diagnosis, and treatment administrative services for American Indian children, according to Code of Federal Regulations, title 42, section 441, subpart B, and Minnesota Rules, part 9505.1693 et seq., when the tribe chooses to provide such services. For purposes of this subdivision, "American Indian" has the meaning given to persons to whom services will be provided for in Code of Federal Regulations, title 42, section 36.12. Notwithstanding Minnesota Rules, part 9505.1748, subpart 1, the commissioner, the local agency, and the tribe may contract with any

entity for the provision of early and periodic screening, diagnosis, and treatment administrative services.

[For text of subds 2 to 19, see M.S.2000]

History: *1Sp2001 c 9 art 2 s 14*

256B.055 ELIGIBILITY CATEGORIES.

[For text of subds 1 to 3, see M.S.2000]

Subd. 3a. **Families with children.** Beginning July 1, 2002, medical assistance may be paid for a person who is a child under the age of 18, or age 18 if a full-time student in a secondary school, or in the equivalent level of vocational or technical training, and reasonably expected to complete the program before reaching age 19; the parent of a dependent child, including a pregnant woman; or a caretaker relative of a dependent child.

[For text of subds 4 to 12, see M.S.2000]

History: *1Sp2001 c 9 art 2 s 15*

NOTE: The amendment to subdivision 3a by Laws 2001, First Special Session chapter 9, article 2, section 15, is effective July 1, 2002. Laws 2001, First Special Session chapter 9, article 2, section 15, the effective date.

256B.056 ELIGIBILITY; RESIDENCY; RESOURCES; INCOME.

[For text of subd 1, see M.S.2000]

Subd. 1a. **Income and assets generally.** Unless specifically required by state law or rule or federal law or regulation, the methodologies used in counting income and assets to determine eligibility for medical assistance for persons whose eligibility category is based on blindness, disability, or age of 65 or more years, the methodologies for the supplemental security income program shall be used. Increases in benefits under title II of the Social Security Act shall not be counted as income for purposes of this subdivision until July 1 of each year. Effective upon federal approval, for children eligible under section 256B.055, subdivision 12, or for home and community-based waiver services whose eligibility for medical assistance is determined without regard to parental income, child support payments, including any payments made by an obligor in satisfaction of or in addition to a temporary or permanent order for child support, and social security payments are not counted as income. For families and children, which includes all other eligibility categories, the methodologies under the state's AFDC plan in effect as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law Number 104-193, shall be used, except that effective July 1, 2002, the $90 and $30 and one-third earned income disregards shall not apply and the disregard specified in subdivision 1c shall apply. For these purposes, a "methodology" does not include an asset or income standard, or accounting method, or method of determining effective dates.

Subd. 1b. **Aged, blind, and disabled income methodology.** The $20 general income disregard allowed under the supplemental security income program is included in the standard and shall not be allowed as a deduction from income for a person eligible under section 256B.055, subdivisions 7, 7a, and 12.

Subd. 1c. **Families with children income methodology.** (a) For children ages one to five whose eligibility is determined under section 256B.057, subdivision 2, 21 percent of countable earned income shall be disregarded for up to four months.

(b) For families with children whose eligibility is determined using the standard specified in section 256B.056, subdivision 4, paragraph (c), 17 percent of countable earned income shall be disregarded for up to four months.

(c) If the disregard has been applied to the wage earner's income for four months, the disregard shall not be applied again until the wage earner's income has not been considered in determining medical assistance eligibility for 12 consecutive months.

[For text of subd 2, see M.S.2000]

Subd. 3. **Asset limitations for elderly and disabled individuals.** To be eligible for medical assistance, a person must not individually own more than $3,000 in assets, or if a member of a household with two family members, husband and wife, or parent and child, the household must not own more than $6,000 in assets, plus $200 for each additional legal dependent. In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. The accumulation of the clothing and personal needs allowance according to section 256B.35 must also be reduced to the maximum at the time of the eligibility redetermination. The value of assets that are not considered in determining eligibility for medical assistance is the value of those assets excluded under the supplemental security income program for aged, blind, and disabled persons, with the following exceptions:

(a) Household goods and personal effects are not considered.

(b) Capital and operating assets of a trade or business that the local agency determines are necessary to the person's ability to earn an income are not considered.

(c) Motor vehicles are excluded to the same extent excluded by the supplemental security income program.

(d) Assets designated as burial expenses are excluded to the same extent excluded by the supplemental security income program.

(e) Effective upon federal approval, for a person who no longer qualifies as an employed person with a disability due to loss of earnings, assets allowed while eligible for medical assistance under section 256B.057, subdivision 9, are not considered for 12 months, beginning with the first month of ineligibility as an employed person with a disability, to the extent that the person's total assets remain within the allowed limits of section 256B.057, subdivision 9, paragraph (b).

[For text of subd 3b, see M.S.2000]

Subd. 3c. **Asset limitations for families and children.** A household of two or more persons must not own more than $30,000 in total net assets, and a household of one person must not own more than $15,000 in total net assets. In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. The value of assets that are not considered in determining eligibility for medical assistance for families and children is the value of those assets excluded under the AFDC state plan as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law Number 104-193, with the following exceptions:

(1) household goods and personal effects are not considered;

(2) capital and operating assets of a trade or business up to $200,000 are not considered;

(3) one motor vehicle is excluded for each person of legal driving age who is employed or seeking employment;

(4) one burial plot and all other burial expenses equal to the supplemental security income program asset limit are not considered for each individual;

(5) court-ordered settlements up to $10,000 are not considered;

(6) individual retirement accounts and funds are not considered; and

(7) assets owned by children are not considered.

Subd. 4. **Income.** (a) To be eligible for medical assistance, a person eligible under section 256B.055, subdivisions 7, 7a, and 12, may have income up to 100 percent of the federal poverty guidelines. Effective January 1, 2000, and each successive January, recipients of supplemental security income may have an income up to the supplemental security income standard in effect on that date.

(b) To be eligible for medical assistance, families and children may have an income up to 133-1/3 percent of the AFDC income standard in effect under the July 16, 1996, AFDC state plan. Effective July 1, 2000, the base AFDC standard in effect on July 16, 1996, shall be increased by three percent.

(c) Effective July 1, 2002, to be eligible for medical assistance, families and children may have an income up to 100 percent of the federal poverty guidelines for the family size.

(d) In computing income to determine eligibility of persons under paragraphs (a) to (c) who are not residents of long-term care facilities, the commissioner shall disregard increases in income as required by Public Law Numbers 94-566, section 503; 99-272; and 99-509. Veterans aid and attendance benefits and Veterans Administration unusual medical expense payments are considered income to the recipient.

[For text of subd 4a, see M.S.2000]

Subd. 4b. **Income verification.** The local agency shall not require a monthly income verification form for a recipient who is a resident of a long-term care facility and who has monthly earned income of $80 or less. The commissioner or county agency shall use electronic verification as the primary method of income verification. If there is a discrepancy between reported income and electronically verified income, an individual may be required to submit additional verification.

Subd. 5. **Excess income.** A person who has excess income is eligible for medical assistance if the person has expenses for medical care that are more than the amount of the person's excess income, computed by deducting incurred medical expenses from the excess income to reduce the excess to the income standard specified in subdivision 5c. The person shall elect to have the medical expenses deducted at the beginning of a one-month budget period or at the beginning of a six-month budget period. The commissioner shall allow persons eligible for assistance on a one-month spenddown basis under this subdivision to elect to pay the monthly spenddown amount in advance of the month of eligibility to the state agency in order to maintain eligibility on a continuous basis. If the recipient does not pay the spenddown amount on or before the 20th of the month, the recipient is ineligible for this option for the following month. The local agency shall code the Medicaid Management Information System (MMIS) to indicate that the recipient has elected this option. The state agency shall convey recipient eligibility information relative to the collection of the spenddown to providers through the Electronic Verification System (EVS). A recipient electing advance payment must pay the state agency the monthly spenddown amount on or before the 20th of the month in order to be eligible for this option in the following month.

Subd. 5a. **Individuals on fixed or excluded income.** Recipients of medical assistance who receive only fixed unearned or excluded income, when that income is excluded from consideration as income or unvarying in amount and timing of receipt throughout the year, shall report and verify their income annually.

[For text of subd 5b, see M.S.2000]

Subd. 5c. **Excess income standard.** (a) The excess income standard for families with children is the standard specified in subdivision 4.

(b) The excess income standard for a person whose eligibility is based on blindness, disability, or age of 65 or more years is 70 percent of the federal poverty guidelines for the family size. Effective July 1, 2002, the excess income standard for this paragraph shall equal 75 percent of the federal poverty guidelines.

[For text of subds 6 to 8, see M.S.2000]

History: *2001 c 203 s 5,6; 1Sp2001 c 9 art 2 s 16-24.*

NOTE: Subdivisions 1c and 3c, as added by Laws 2001, First Special Session chapter 9, article 2, sections 18 and 20, are effective July 1, 2002. Laws 2001, First Special Session chapter 9, article 2, sections 18 and 20, the effective dates.

256B.057 ELIGIBILITY; INCOME AND ASSET LIMITATIONS FOR SPECIAL CATEGORIES.

[For text of subds 1 to 1c, see M.S.2000]

Subd. 2. **Children.** Except as specified in subdivision 1b, effective July 1, 2002, a child one through 18 years of age in a family whose countable income is no greater than 170 percent of the federal poverty guidelines for the same family size, is eligible for medical assistance.

Subd. 3. **Qualified Medicare beneficiaries.** A person who is entitled to Part A Medicare benefits, whose income is equal to or less than 100 percent of the federal poverty guidelines, and whose assets are no more than $10,000 for a single individual and $18,000 for a married couple or family of two or more, is eligible for medical assistance reimbursement of Part A and Part B premiums, Part A and Part B coinsurance and deductibles, and cost-effective premiums for enrollment with a health maintenance organization or a competitive medical plan under section 1876 of the Social Security Act. Reimbursement of the Medicare coinsurance and deductibles, when added to the amount paid by Medicare, must not exceed the total rate the provider would have received for the same service or services if the person were a medical assistance recipient with Medicare coverage. Increases in benefits under Title II of the Social Security Act shall not be counted as income for purposes of this subdivision until July 1 of each year.

[For text of subds 3a to 6, see M.S.2000]

Subd. 7. **Waiver of maintenance of effort requirement.** Unless a federal waiver of the maintenance of effort requirement of section 2105(d) of title XXI of the Balanced Budget Act of 1997, Public Law Number 105-33, Statutes at Large, volume 111, page 251, is granted by the federal Department of Health and Human Services by September 30, 1998, eligibility for children under age 21 must be determined without regard to asset standards established in section 256B.056, subdivision 3c. The commissioner of human services shall publish a notice in the State Register upon receipt of a federal waiver.

[For text of subd 8, see M.S.2000]

Subd. 9. **Employed persons with disabilities.** (a) Medical assistance may be paid for a person who is employed and who:

(1) meets the definition of disabled under the supplemental security income program;

(2) is at least 16 but less than 65 years of age;

(3) meets the asset limits in paragraph (b); and

(4) pays a premium, if required, under paragraph (c).

Any spousal income or assets shall be disregarded for purposes of eligibility and premium determinations.

After the month of enrollment, a person enrolled in medical assistance under this subdivision who is temporarily unable to work and without receipt of earned income due to a medical condition, as verified by a physician, may retain eligibility for up to four calendar months.

(b) For purposes of determining eligibility under this subdivision, a person's assets must not exceed $20,000, excluding:

(1) all assets excluded under section 256B.056;

(2) retirement accounts, including individual accounts, 401(k) plans, 403(b) plans, Keogh plans, and pension plans; and

(3) medical expense accounts set up through the person's employer.

(c) A person whose earned and unearned income is equal to or greater than 100 percent of federal poverty guidelines for the applicable family size must pay a premium

to be eligible for medical assistance under this subdivision. The premium shall be based on the person's gross earned and unearned income and the applicable family size using a sliding fee scale established by the commissioner, which begins at one percent of income at 100 percent of the federal poverty guidelines and increases to 7.5 percent of income for those with incomes at or above 300 percent of the federal poverty guidelines. Annual adjustments in the premium schedule based upon changes in the federal poverty guidelines shall be effective for premiums due in July of each year.

(d) A person's eligibility and premium shall be determined by the local county agency. Premiums must be paid to the commissioner. All premiums are dedicated to the commissioner.

(e) Any required premium shall be determined at application and redetermined annually at recertification or when a change in income or family size occurs.

(f) Premium payment is due upon notification from the commissioner of the premium amount required. Premiums may be paid in installments at the discretion of the commissioner.

(g) Nonpayment of the premium shall result in denial or termination of medical assistance unless the person demonstrates good cause for nonpayment. Good cause exists if the requirements specified in Minnesota Rules, part 9506.0040, subpart 7, items B to D, are met. Nonpayment shall include payment with a returned, refused, or dishonored instrument. The commissioner may require a guaranteed form of payment as the only means to replace a returned, refused, or dishonored instrument.

Subd. 10. **Certain persons needing treatment for breast or cervical cancer.** (a) Medical assistance may be paid for a person who:

(1) has been screened for breast or cervical cancer by the Minnesota breast and cervical cancer control program, and program funds have been used to pay for the person's screening;

(2) according to the person's treating health professional, needs treatment, including diagnostic services necessary to determine the extent and proper course of treatment, for breast or cervical cancer, including precancerous conditions and early stage cancer;

(3) meets the income eligibility guidelines for the Minnesota breast and cervical cancer control program;

(4) is under age 65;

(5) is not otherwise eligible for medical assistance under United States Code, title 42, section 1396(a)(10)(A)(i); and

(6) is not otherwise covered under creditable coverage, as defined under United States Code, title 42, section 300gg(c).

(b) Medical assistance provided for an eligible person under this subdivision shall be limited to services provided during the period that the person receives treatment for breast or cervical cancer.

(c) A person meeting the criteria in paragraph (a) is eligible for medical assistance without meeting the eligibility criteria relating to income and assets in section 256B.056, subdivisions 1a to 5b.

History: *1Sp2001 c 9 art 2 s 25-29*

NOTE: The amendment to subdivision 2 by Laws 2001, First Special Session chapter 9, article 2, section 25, is effective July 1, 2002. Laws 2001, First Special Session chapter 9, article 2, section 25, the effective date.

NOTE: Subdivision 10, as added by Laws 2001, First Special Session chapter 9, article 2, section 29, is effective July 1, 2002. Laws 2001, First Special Session chapter 9, article 2, section 29, the effective date.

256B.0595 PROHIBITIONS ON TRANSFER; EXCEPTIONS.

Subdivision 1. **Prohibited transfers.** (a) For transfers of assets made on or before August 10, 1993, if a person or the person's spouse has given away, sold, or disposed of, for less than fair market value, any asset or interest therein, except assets other than the homestead that are excluded under the supplemental security program, within 30 months before or any time after the date of institutionalization if the person has been

determined eligible for medical assistance, or within 30 months before or any time after the date of the first approved application for medical assistance if the person has not yet been determined eligible for medical assistance, the person is ineligible for long-term care services for the period of time determined under subdivision 2.

(b) Effective for transfers made after August 10, 1993, a person, a person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the person or person's spouse, may not give away, sell, or dispose of, for less than fair market value, any asset or interest therein, except assets other than the homestead that are excluded under the supplemental security income program, for the purpose of establishing or maintaining medical assistance eligibility. For purposes of determining eligibility for long-term care services, any transfer of such assets within 36 months before or any time after an institutionalized person applies for medical assistance, or 36 months before or any time after a medical assistance recipient becomes institutionalized, for less than fair market value may be considered. Any such transfer is presumed to have been made for the purpose of establishing or maintaining medical assistance eligibility and the person is ineligible for long-term care services for the period of time determined under subdivision 2, unless the person furnishes convincing evidence to establish that the transaction was exclusively for another purpose, or unless the transfer is permitted under subdivision 3 or 4. Notwithstanding the provisions of this paragraph, in the case of payments from a trust or portions of a trust that are considered transfers of assets under federal law, any transfers made within 60 months before or any time after an institutionalized person applies for medical assistance and within 60 months before or any time after a medical assistance recipient becomes institutionalized, may be considered.

(c) This section applies to transfers, for less than fair market value, of income or assets, including assets that are considered income in the month received, such as inheritances, court settlements, and retroactive benefit payments or income to which the person or the person's spouse is entitled but does not receive due to action by the person, the person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the person or the person's spouse.

(d) This section applies to payments for care or personal services provided by a relative, unless the compensation was stipulated in a notarized, written agreement which was in existence when the service was performed, the care or services directly benefited the person, and the payments made represented reasonable compensation for the care or services provided. A notarized written agreement is not required if payment for the services was made within 60 days after the service was provided.

(e) This section applies to the portion of any asset or interest that a person, a person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the person or the person's spouse, transfers to any annuity that exceeds the value of the benefit likely to be returned to the person or spouse while alive, based on estimated life expectancy using the life expectancy tables employed by the supplemental security income program to determine the value of an agreement for services for life. The commissioner may adopt rules reducing life expectancies based on the need for long-term care.

(f) For purposes of this section, long-term care services include services in a nursing facility, services that are eligible for payment according to section 256B.0625, subdivision 2, because they are provided in a swing bed, intermediate care facility for persons with mental retardation, and home and community-based services provided pursuant to sections 256B.0915, 256B.092, and 256B.49. For purposes of this subdivision and subdivisions 2, 3, and 4, "institutionalized person" includes a person who is an inpatient in a nursing facility or in a swing bed, or intermediate care facility for persons with mental retardation or who is receiving home and community-based services under sections 256B.0915, 256B.092, and 256B.49.

Subd. 1a. [Repealed, 2001 c 203 s 19]

Subd. 2. **Period of ineligibility.** (a) For any uncompensated transfer occurring on or before August 10, 1993, the number of months of ineligibility for long-term care services shall be the lesser of 30 months, or the uncompensated transfer amount divided by the average medical assistance rate for nursing facility services in the state in effect on the date of application. The amount used to calculate the average medical assistance payment rate shall be adjusted each July 1 to reflect payment rates for the previous calendar year. The period of ineligibility begins with the month in which the assets were transferred. If the transfer was not reported to the local agency at the time of application, and the applicant received long-term care services during what would have been the period of ineligibility if the transfer had been reported, a cause of action exists against the transferee for the cost of long-term care services provided during the period of ineligibility, or for the uncompensated amount of the transfer, whichever is less. The action may be brought by the state or the local agency responsible for providing medical assistance under chapter 256G. The uncompensated transfer amount is the fair market value of the asset at the time it was given away, sold, or disposed of, less the amount of compensation received.

(b) For uncompensated transfers made after August 10, 1993, the number of months of ineligibility for long-term care services shall be the total uncompensated value of the resources transferred divided by the average medical assistance rate for nursing facility services in the state in effect on the date of application. The amount used to calculate the average medical assistance payment rate shall be adjusted each July 1 to reflect payment rates for the previous calendar year. The period of ineligibility begins with the month in which the assets were transferred except that if one or more uncompensated transfers are made during a period of ineligibility, the total assets transferred during the ineligibility period shall be combined and a penalty period calculated to begin in the month the first uncompensated transfer was made. If the transfer was not reported to the local agency at the time of application, and the applicant received medical assistance services during what would have been the period of ineligibility if the transfer had been reported, a cause of action exists against the transferee for the cost of medical assistance services provided during the period of ineligibility, or for the uncompensated amount of the transfer, whichever is less. The action may be brought by the state or the local agency responsible for providing medical assistance under chapter 256G. The uncompensated transfer amount is the fair market value of the asset at the time it was given away, sold, or disposed of, less the amount of compensation received. Effective for transfers made on or after March 1, 1996, involving persons who apply for medical assistance on or after April 13, 1996, no cause of action exists for a transfer unless:

(1) the transferee knew or should have known that the transfer was being made by a person who was a resident of a long-term care facility or was receiving that level of care in the community at the time of the transfer;

(2) the transferee knew or should have known that the transfer was being made to assist the person to qualify for or retain medical assistance eligibility; or

(3) the transferee actively solicited the transfer with intent to assist the person to qualify for or retain eligibility for medical assistance.

(c) If a calculation of a penalty period results in a partial month, payments for long-term care services shall be reduced in an amount equal to the fraction, except that in calculating the value of uncompensated transfers, if the total value of all uncompensated transfers made in a month not included in an existing penalty period does not exceed $500, then such transfers shall be disregarded for each month prior to the month of application for or during receipt of medical assistance.

Subd. 2a. [Repealed, 2001 c 203 s 19]

[For text of subd 3, see M.S.2000]

Subd. 3a. [Repealed, 2001 c 203 s 19]

[For text of subd 4, see M.S.2000]

Subd. 4a. [Repealed, 2001 c 203 s 19]

[For text of subds 5 to 7, see M.S.2000]

History: *2001 c 203 s 7,8,19*

256B.0621 COVERED SERVICES: TARGETED CASE MANAGEMENT SERVICES.

Subdivision 1. **Targeted case management services.** Medical assistance covers case management services for vulnerable adults and persons with developmental disabilities not receiving home and community-based waiver services.

Subd. 2. **Targeted case management; definitions.** For purposes of subdivisions 3 to 10, the following terms have the meanings given them:

(1) "home care service recipients" means those individuals receiving the following services under section 256B.0627: skilled nursing visits, home health aide visits, private duty nursing, personal care assistants, or therapies provided through a home health agency;

(2) "home care targeted case management" means the provision of targeted case management services for the purpose of assisting home care service recipients to gain access to needed services and supports so that they may remain in the community;

(3) "institutions" means hospitals, consistent with Code of Federal Regulations, title 42, section 440.10; regional treatment center inpatient services, consistent with section 245.474; nursing facilities; and intermediate care facilities for persons with mental retardation;

(4) "relocation targeted case management" means the provision of targeted case management services for the purpose of assisting recipients to gain access to needed services and supports if they choose to move from an institution to the community. Relocation targeted case management may be provided during the last 180 consecutive days of an eligible recipient's institutional stay; and

(5) "targeted case management" means case management services provided to help recipients gain access to needed medical, social, educational, and other services and supports.

Subd. 3. **Eligibility.** The following persons are eligible for relocation targeted case management or home care-targeted case management:

(1) medical assistance eligible persons residing in institutions who choose to move into the community are eligible for relocation targeted case management services; and

(2) medical assistance eligible persons receiving home care services, who are not eligible for any other medical assistance reimbursable case management service, are eligible for home care-targeted case management services beginning January 1, 2003.

Subd. 4. **Relocation targeted case management provider qualifications.** The following qualifications and certification standards must be met by providers of relocation targeted case management:

(a) The commissioner must certify each provider of relocation targeted case management before enrollment. The certification process shall examine the provider's ability to meet the requirements in this subdivision and other federal and state requirements of this service. A certified relocation targeted case management provider may subcontract with another provider to deliver relocation targeted case management services. Subcontracted providers must demonstrate the ability to provide the services outlined in subdivision 6.

(b) A relocation targeted case management provider is an enrolled medical assistance provider who is determined by the commissioner to have all of the following characteristics:

(1) the legal authority to provide public welfare under sections 393.01, subdivision 7; and 393.07; or a federally recognized Indian tribe;

(2) the demonstrated capacity and experience to provide the components of case management to coordinate and link community resources needed by the eligible population;

(3) the administrative capacity and experience to serve the target population for whom it will provide services and ensure quality of services under state and federal requirements;

(4) the legal authority to provide complete investigative and protective services under section 626.556, subdivision 10; and child welfare and foster care services under section 393.07, subdivisions 1 and 2; or a federally recognized Indian tribe;

(5) a financial management system that provides accurate documentation of services and costs under state and federal requirements; and

(6) the capacity to document and maintain individual case records under state and federal requirements.

A provider of targeted case management under subdivision 20 may be deemed a certified provider of relocation targeted case management.

Subd. 5. **Home care targeted case management provider qualifications.** The following qualifications and certification standards must be met by providers of home care targeted case management.

(a) The commissioner must certify each provider of home care targeted case management before enrollment. The certification process shall examine the provider's ability to meet the requirements in this subdivision and other state and federal requirements of this service.

(b) A home care targeted case management provider is an enrolled medical assistance provider who has a minimum of a bachelor's degree or a license in a health or human services field, and is determined by the commissioner to have all of the following characteristics:

(1) the demonstrated capacity and experience to provide the components of case management to coordinate and link community resources needed by the eligible population;

(2) the administrative capacity and experience to serve the target population for whom it will provide services and ensure quality of services under state and federal requirements;

(3) a financial management system that provides accurate documentation of services and costs under state and federal requirements;

(4) the capacity to document and maintain individual case records under state and federal requirements; and

(5) the capacity to coordinate with county administrative functions.

Subd. 6. **Eligible services.** Services eligible for medical assistance reimbursement as targeted case management include:

(1) assessment of the recipient's need for targeted case management services;

(2) development, completion, and regular review of a written individual service plan, which is based upon the assessment of the recipient's needs and choices, and which will ensure access to medical, social, educational, and other related services and supports;

(3) routine contact or communication with the recipient, recipient's family, primary caregiver, legal representative, substitute care provider, service providers, or other relevant persons identified as necessary to the development or implementation of the goals of the individual service plan;

(4) coordinating referrals for, and the provision of, case management services for the recipient with appropriate service providers, consistent with section 1902(a)(23) of the Social Security Act;

(5) coordinating and monitoring the overall service delivery to ensure quality of services, appropriateness, and continued need;

(6) completing and maintaining necessary documentation that supports and verifies the activities in this subdivision;

(7) traveling to conduct a visit with the recipient or other relevant person necessary to develop or implement the goals of the individual service plan; and

(8) coordinating with the institution discharge planner in the 180-day period before the recipient's discharge.

Subd. 7. **Time lines.** The following time lines must be met for assigning a case manager:

(1) for relocation targeted case management, an eligible recipient must be assigned a case manager who visits the person within 20 working days of requesting a case manager from their county of financial responsibility as determined under chapter 256G. If a county agency does not provide case management services as required, the recipient may, after written notice to the county agency, obtain targeted relocation case management services from a home care targeted case management provider, as defined in subdivision 5; and

(2) for home care targeted case management, an eligible recipient must be assigned a case manager within 20 working days of requesting a case manager from a home care targeted case management provider, as defined in subdivision 5.

Subd. 8. **Evaluation.** The commissioner shall evaluate the delivery of targeted case management, including, but not limited to, access to case management services, consumer satisfaction with case management services, and quality of case management services.

Subd. 9. **Contact documentation.** The case manager must document each face-to-face and telephone contact with the recipient and others involved in the recipient's individual service plan.

Subd. 10. **Payment rates.** The commissioner shall set payment rates for targeted case management under this subdivision. Case managers may bill according to the following criteria:

(1) for relocation targeted case management, case managers may bill for direct case management activities, including face-to-face and telephone contacts, in the 180 days preceding an eligible recipient's discharge from an institution;

(2) for home care targeted case management, case managers may bill for direct case management activities, including face-to-face and telephone contacts; and

(3) billings for targeted case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

History: *1Sp2001 c 9 art 2 s 39; art 3 s 20-28*

NOTE: Subdivision 5, as added by Laws 2001, First Special Session chapter 9, article 3, section 23, is effective January 1, 2003. Laws 2001, First Special Session chapter 9, article 3, section 77.

256B.0623 COVERED SERVICE: ADULT REHABILITATIVE MENTAL HEALTH SERVICES.

Subdivision 1. **Scope.** Medical assistance covers adult rehabilitative mental health services as defined in subdivision 2, subject to federal approval, if provided to recipients as defined in subdivision 3 and provided by a qualified provider entity meeting the standards in this section and by a qualified individual provider working within the provider's scope of practice and identified in the recipient's individual treatment plan as defined in section 245.462, subdivision 14, and if determined to be medically necessary according to section 62Q.53.

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Adult rehabilitative mental health services" means mental health services which are rehabilitative and enable the recipient to develop and enhance psychiatric stability, social competencies, personal and emotional adjustment, and independent living and community skills, when these abilities are impaired by the symptoms of mental illness. Adult rehabilitative mental health services are also appropriate when

provided to enable a recipient to retain stability and functioning, if the recipient would be at risk of significant functional decompensation or more restrictive service settings without these services.

(1) Adult rehabilitative mental health services instruct, assist, and support the recipient in areas such as: interpersonal communication skills, community resource utilization and integration skills, crisis assistance, relapse prevention skills, health care directives, budgeting and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills, transportation skills, medication education and monitoring, mental illness symptom management skills, household management skills, employment-related skills, and transition to community living services.

(2) These services shall be provided to the recipient on a one-to-one basis in the recipient's home or another community setting or in groups.

(b) "Medication education services" means services provided individually or in groups which focus on educating the recipient about mental illness and symptoms; the role and effects of medications in treating symptoms of mental illness; and the side effects of medications. Medication education is coordinated with medication management services and does not duplicate it. Medication education services are provided by physicians, pharmacists, or registered nurses.

(c) "Transition to community living services" means services which maintain continuity of contact between the rehabilitation services provider and the recipient and which facilitate discharge from a hospital, residential treatment program under Minnesota Rules, chapter 9505, board and lodging facility, or nursing home. Transition to community living services are not intended to provide other areas of adult rehabilitative mental health services.

Subd. 3. **Eligibility.** An eligible recipient is an individual who:

(1) is age 18 or older;

(2) is diagnosed with a medical condition, such as mental illness or traumatic brain injury, for which adult rehabilitative mental health services are needed;

(3) has substantial disability and functional impairment in three or more of the areas listed in section 245.462, subdivision 11a, so that self-sufficiency is markedly reduced; and

(4) has had a recent diagnostic assessment by a qualified professional that documents adult rehabilitative mental health services are medically necessary to address identified disability and functional impairments and individual recipient goals.

Subd. 4. **Provider entity standards.** (a) The provider entity must be:

(1) a county operated entity certified by the state; or

(2) a noncounty entity certified by the entity's host county.

(b) The certification process is a determination as to whether the entity meets the standards in this subdivision. The certification must specify which adult rehabilitative mental health services the entity is qualified to provide.

(c) If an entity seeks to provide services outside its host county, it must obtain additional certification from each county in which it will provide services. The additional certification must be based on the adequacy of the entity's knowledge of that county's local health and human service system, and the ability of the entity to coordinate its services with the other services available in that county.

(d) Recertification must occur at least every two years.

(e) The commissioner may intervene at any time and decertify providers with cause. The decertification is subject to appeal to the state. A county board may recommend that the state decertify a provider for cause.

(f) The adult rehabilitative mental health services provider entity must meet the following standards:

(1) have capacity to recruit, hire, manage, and train mental health professionals, mental health practitioners, and mental health rehabilitation workers;

(2) have adequate administrative ability to ensure availability of services;

(3) ensure adequate preservice and inservice training for staff;

(4) ensure that mental health professionals, mental health practitioners, and mental health rehabilitation workers are skilled in the delivery of the specific adult rehabilitative mental health services provided to the individual eligible recipient;

(5) ensure that staff is capable of implementing culturally specific services that are culturally competent and appropriate as determined by the recipient's culture, beliefs, values, and language as identified in the individual treatment plan;

(6) ensure enough flexibility in service delivery to respond to the changing and intermittent care needs of a recipient as identified by the recipient and the individual treatment plan;

(7) ensure that the mental health professional or mental health practitioner, who is under the clinical supervision of a mental health professional, involved in a recipient's services participates in the development of the individual treatment plan;

(8) assist the recipient in arranging needed crisis assessment, intervention, and stabilization services;

(9) ensure that services are coordinated with other recipient mental health services providers and the county mental health authority and the federally recognized American Indian authority and necessary others after obtaining the consent of the recipient. Services must also be coordinated with the recipient's case manager or care coordinator if the recipient is receiving case management or care coordination services;

(10) develop and maintain recipient files, individual treatment plans, and contact charting;

(11) develop and maintain staff training and personnel files;

(12) submit information as required by the state;

(13) establish and maintain a quality assurance plan to evaluate the outcome of services provided;

(14) keep all necessary records required by law;

(15) deliver services as required by section 245.461;

(16) comply with all applicable laws;

(17) be an enrolled Medicaid provider;

(18) maintain a quality assurance plan to determine specific service outcomes and the recipient's satisfaction with services; and

(19) develop and maintain written policies and procedures regarding service provision and administration of the provider entity.

(g) The commissioner shall develop statewide procedures for provider certification, including timelines for counties to certify qualified providers.

Subd. 5. **Qualifications of provider staff.** Adult rehabilitative mental health services must be provided by qualified individual provider staff of a certified provider entity. Individual provider staff must be qualified under one of the following criteria:

(1) a mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (5);

(2) a mental health practitioner as defined in section 245.462, subdivision 17. The mental health practitioner must work under the clinical supervision of a mental health professional; or

(3) a mental health rehabilitation worker. A mental health rehabilitation worker means a staff person working under the direction of a mental health practitioner or mental health professional and under the clinical supervision of a mental health professional in the implementation of rehabilitative mental health services as identified in the recipient's individual treatment plan who:

(i) is at least 21 years of age;

(ii) has a high school diploma or equivalent;

(iii) has successfully completed 30 hours of training during the past two years in all of the following areas: recipient rights, recipient-centered individual treatment plan-

ning, behavioral terminology, mental illness, co-occurring mental illness and substance abuse, psychotropic medications and side effects, functional assessment, local community resources, adult vulnerability, recipient confidentiality; and

(iv) meets the qualifications in subitem (A) or (B):

(A) has an associate of arts degree in one of the behavioral sciences or human services, or is a registered nurse without a bachelor's degree, or who within the previous ten years has:

(1) three years of personal life experience with serious and persistent mental illness;

(2) three years of life experience as a primary caregiver to an adult with a serious mental illness or traumatic brain injury; or

(3) 4,000 hours of supervised paid work experience in the delivery of mental health services to adults with a serious mental illness or traumatic brain injury; or

(B)(1) is fluent in the non-English language or competent in the culture of the ethnic group to which at least 50 percent of the mental health rehabilitation worker's clients belong;

(2) receives during the first 2,000 hours of work, monthly documented individual clinical supervision by a mental health professional;

(3) has 18 hours of documented field supervision by a mental health professional or practitioner during the first 160 hours of contact work with recipients, and at least six hours of field supervision quarterly during the following year;

(4) has review and cosignature of charting of recipient contacts during field supervision by a mental health professional or practitioner; and

(5) has 40 hours of additional continuing education on mental health topics during the first year of employment.

Subd. 6. **Required training and supervision.** (a) Mental health rehabilitation workers must receive ongoing continuing education training of at least 30 hours every two years in areas of mental illness and mental health services and other areas specific to the population being served. Mental health rehabilitation workers must also be subject to the ongoing direction and clinical supervision standards in paragraphs (c) and (d).

(b) Mental health practitioners must receive ongoing continuing education training as required by their professional license; or if the practitioner is not licensed, the practitioner must receive ongoing continuing education training of at least 30 hours every two years in areas of mental illness and mental health services. Mental health practitioners must meet the ongoing clinical supervision standards in paragraph (c).

(c) A mental health professional providing clinical supervision of staff delivering adult rehabilitative mental health services must provide the following guidance:

(1) review the information in the recipient's file;

(2) review and approve initial and updates of individual treatment plans;

(3) meet with mental health rehabilitation workers and practitioners, individually or in small groups, at least monthly to discuss treatment topics of interest to the workers and practitioners;

(4) meet with mental health rehabilitation workers and practitioners, individually or in small groups, at least monthly to discuss treatment plans of recipients, and approve by signature and document in the recipient's file any resulting plan updates;

(5) meet at least twice a month with the directing mental health practitioner, if there is one, to review needs of the adult rehabilitative mental health services program, review staff on-site observations and evaluate mental health rehabilitation workers, plan staff training, review program evaluation and development, and consult with the directing practitioner;

(6) be available for urgent consultation as the individual recipient needs or the situation necessitates; and

(7) provide clinical supervision by full- or part-time mental health professionals employed by or under contract with the provider entity.

(d) An adult rehabilitative mental health services provider entity must have a treatment director who is a mental health practitioner or mental health professional. The treatment director must ensure the following:

(1) while delivering direct services to recipients, a newly hired mental health rehabilitation worker must be directly observed delivering services to recipients by the mental health practitioner or mental health professional for at least six hours per 40 hours worked during the first 160 hours that the mental health rehabilitation worker works;

(2) the mental health rehabilitation worker must receive ongoing on-site direct service observation by a mental health professional or mental health practitioner for at least six hours for every six months of employment;

(3) progress notes are reviewed from on-site service observation prepared by the mental health rehabilitation worker and mental health practitioner for accuracy and consistency with actual recipient contact and the individual treatment plan and goals;

(4) immediate availability by phone or in person for consultation by a mental health professional or a mental health practitioner to the mental health rehabilitation services worker during service provision;

(5) oversee the identification of changes in individual recipient treatment strategies, revise the plan, and communicate treatment instructions and methodologies as appropriate to ensure that treatment is implemented correctly;

(6) model service practices which: respect the recipient, include the recipient in planning and implementation of the individual treatment plan, recognize the recipient's strengths, collaborate and coordinate with other involved parties and providers;

(7) ensure that mental health practitioners and mental health rehabilitation workers are able to effectively communicate with the recipients, significant others, and providers; and

(8) oversee the record of the results of on-site observation and charting evaluation and corrective actions taken to modify the work of the mental health practitioners and mental health rehabilitation workers.

(e) A mental health practitioner who is providing treatment direction for a provider entity must receive supervision at least monthly from a mental health professional to:

(1) identify and plan for general needs of the recipient population served;

(2) identify and plan to address provider entity program needs and effectiveness;

(3) identify and plan provider entity staff training and personnel needs and issues; and

(4) plan, implement, and evaluate provider entity quality improvement programs.

Subd. 7. **Personnel file.** The adult rehabilitative mental health services provider entity must maintain a personnel file on each staff. Each file must contain:

(1) an annual performance review;

(2) a summary of on-site service observations and charting review;

(3) a criminal background check of all direct service staff;

(4) evidence of academic degree and qualifications;

(5) a copy of professional license;

(6) any job performance recognition and disciplinary actions;

(7) any individual staff written input into own personnel file;

(8) all clinical supervision provided; and

(9) documentation of compliance with continuing education requirements.

Subd. 8. **Diagnostic assessment.** Providers of adult rehabilitative mental health services must complete a diagnostic assessment as defined in section 245.462, subdivision 9, within five days after the recipient's second visit or within 30 days after intake,

whichever occurs first. In cases where a diagnostic assessment is available that reflects the recipient's current status, and has been completed within 180 days preceding admission, an update must be completed. An update shall include a written summary by a mental health professional of the recipient's current mental health status and service needs. If the recipient's mental health status has changed significantly since the adult's most recent diagnostic assessment, a new diagnostic assessment is required.

Subd. 9. **Functional assessment.** Providers of adult rehabilitative mental health services must complete a written functional assessment as defined in section 245.462, subdivision 11a, for each recipient. The functional assessment must be completed within 30 days of intake, and reviewed and updated at least every six months after it is developed, unless there is a significant change in the functioning of the recipient. If there is a significant change in functioning, the assessment must be updated. A single functional assessment can meet case management and adult rehabilitative mental health services requirements if agreed to by the recipient. Unless the recipient refuses, the recipient must have significant participation in the development of the functional assessment.

Subd. 10. **Individual treatment plan.** All providers of adult rehabilitative mental health services must develop and implement an individual treatment plan for each recipient. The provisions in clauses (1) and (2) apply:

(1) Individual treatment plan means a plan of intervention, treatment, and services for an individual recipient written by a mental health professional or by a mental health practitioner under the clinical supervision of a mental health professional. The individual treatment plan must be based on diagnostic and functional assessments. To the extent possible, the development and implementation of a treatment plan must be a collaborative process involving the recipient, and with the permission of the recipient, the recipient's family and others in the recipient's support system. Providers of adult rehabilitative mental health services must develop the individual treatment plan within 30 calendar days of intake. The treatment plan must be updated at least every six months thereafter, or more often when there is significant change in the recipient's situation or functioning, or in services or service methods to be used, or at the request of the recipient or the recipient's legal guardian.

(2) The individual treatment plan must include:

(i) a list of problems identified in the assessment;

(ii) the recipient's strengths and resources;

(iii) concrete, measurable goals to be achieved, including time frames for achievement;

(iv) specific objectives directed toward the achievement of each one of the goals;

(v) documentation of participants in the treatment planning. The recipient, if possible, must be a participant. The recipient or the recipient's legal guardian must sign the treatment plan, or documentation must be provided why this was not possible. A copy of the plan must be given to the recipient or legal guardian. Referral to formal services must be arranged, including specific providers where applicable;

(vi) cultural considerations, resources, and needs of the recipient must be included;

(vii) planned frequency and type of services must be initiated; and

(viii) clear progress notes on outcome of goals.

(3) The individual community support plan defined in section 245.462, subdivision 12, may serve as the individual treatment plan if there is involvement of a mental health case manager, and with the approval of the recipient. The individual community support plan must include the criteria in clause (2).

Subd. 11. **Recipient file.** Providers of adult rehabilitative mental health services must maintain a file for each recipient that contains the following information:

(1) diagnostic assessment or verification of its location that is current and that was reviewed by a mental health professional who is employed by, or under contract with the provider entity;

(2) functional assessments;

(3) individual treatment plans signed by the recipient and the mental health professional, or if the recipient refused to sign the plan, the date and reason stated by the recipient as to why the recipient would not sign the plan;

(4) recipient history;

(5) signed release forms;

(6) recipient health information and current medications;

(7) emergency contacts for the recipient;

(8) case records which document the date of service, the place of service delivery, signature of the person providing the service, nature, extent and units of service, and place of service delivery;

(9) contacts, direct or by telephone, with recipient's family or others, other providers, or other resources for service coordination;

(10) summary of recipient case reviews by staff; and

(11) written information by the recipient that the recipient requests be included in the file.

Subd. 12. **Additional requirements.** (a) Providers of adult rehabilitative mental health services must comply with the requirements relating to referrals for case management in section 245.467, subdivision 4.

(b) Adult rehabilitative mental health services are provided for most recipients in the recipient's home and community. Services may also be provided at the home of a relative or significant other, job site, psychosocial clubhouse, drop-in center, social setting, classroom, or other places in the community. Except for "transition to community services," the place of service does not include a regional treatment center, nursing home, residential treatment facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670 (Rule 36), or an acute care hospital.

(c) Adult rehabilitative mental health services may be provided in group settings if appropriate to each participating recipient's needs and treatment plan. A group is defined as two to ten clients, at least one of whom is a recipient, who is concurrently receiving a service which is identified in this section. The service and group must be specified in the recipient's treatment plan. No more than two qualified staff may bill Medicaid for services provided to the same group of recipients. If two adult rehabilitative mental health workers bill for recipients in the same group session, they must each bill for different recipients.

Subd. 13. **Excluded services.** The following services are excluded from reimbursement as adult rehabilitative mental health services:

(1) recipient transportation services;

(2) a service provided and billed by a provider who is not enrolled to provide adult rehabilitative mental health service;

(3) adult rehabilitative mental health services performed by volunteers;

(4) provider performance of household tasks, chores, or related activities, such as laundering clothes, moving the recipient's household, housekeeping, and grocery shopping for the recipient;

(5) direct billing of time spent "on call" when not delivering services to recipients;

(6) activities which are primarily social or recreational in nature, rather than rehabilitative, for the individual recipient, as determined by the individual's needs and treatment plan;

(7) job-specific skills services, such as on-the-job training;

(8) provider service time included in case management reimbursement;

(9) outreach services to potential recipients;

(10) a mental health service that is not medically necessary; and

(11) any services provided by a hospital, board and lodging, or residential facility to an individual who is a patient in or resident of that facility.

Subd. 14. **Billing when services are provided by qualified state staff.** When rehabilitative services are provided by qualified state staff who are assigned to pilot projects under section 245.4661, the county or other local entity to which the qualified state staff are assigned may consider these staff part of the local provider entity for which certification is sought under this section and may bill the medical assistance program for qualifying services provided by the qualified state staff. Notwithstanding section 256.025, subdivision 2, payments for services provided by state staff who are assigned to adult mental health initiatives shall only be made from federal funds.

History: *1Sp2001 c 9 art 9 s 39*

256B.0624 COVERED SERVICE: ADULT MENTAL HEALTH CRISIS RESPONSE SERVICES.

Subdivision 1. **Scope.** Medical assistance covers adult mental health crisis response services as defined in subdivision 2, paragraphs (c) to (e), subject to federal approval, if provided to a recipient as defined in subdivision 3 and provided by a qualified provider entity as defined in this section and by a qualified individual provider working within the provider's scope of practice and as defined in this subdivision and identified in the recipient's individual crisis treatment plan as defined in subdivision 11 and if determined to be medically necessary.

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Mental health crisis" is an adult behavioral, emotional, or psychiatric situation which, but for the provision of crisis response services, would likely result in significantly reduced levels of functioning in primary activities of daily living, or in an emergency situation, or in the placement of the recipient in a more restrictive setting, including, but not limited to, inpatient hospitalization.

(b) "Mental health emergency" is an adult behavioral, emotional, or psychiatric situation which causes an immediate need for mental health services and is consistent with section 62Q.55.

A mental health crisis or emergency is determined for medical assistance service reimbursement by a physician, a mental health professional, or crisis mental health practitioner with input from the recipient whenever possible.

(c) "Mental health crisis assessment" means an immediate face-to-face assessment by a physician, a mental health professional, or mental health practitioner under the clinical supervision of a mental health professional, following a screening that suggests that the adult may be experiencing a mental health crisis or mental health emergency situation.

(d) "Mental health mobile crisis intervention services" means face-to-face, short-term intensive mental health services initiated during a mental health crisis or mental health emergency to help the recipient cope with immediate stressors, identify and utilize available resources and strengths, and begin to return to the recipient's baseline level of functioning.

(1) This service is provided on-site by a mobile crisis intervention team outside of an inpatient hospital setting. Mental health mobile crisis intervention services must be available 24 hours a day, seven days a week.

(2) The initial screening must consider other available services to determine which service intervention would best address the recipient's needs and circumstances.

(3) The mobile crisis intervention team must be available to meet promptly face-to-face with a person in mental health crisis or emergency in a community setting.

(4) The intervention must consist of a mental health crisis assessment and a crisis treatment plan.

(5) The treatment plan must include recommendations for any needed crisis stabilization services for the recipient.

(e) "Mental health crisis stabilization services" means individualized mental health services provided to a recipient following crisis intervention services which are designed

to restore the recipient to the recipient's prior functional level. Mental health crisis stabilization services may be provided in the recipient's home, the home of a family member or friend of the recipient, another community setting, or a short-term supervised, licensed residential program. Mental health crisis stabilization does not include partial hospitalization or day treatment.

Subd. 3. **Eligibility.** An eligible recipient is an individual who:

(1) is age 18 or older;

(2) is screened as possibly experiencing a mental health crisis or emergency where a mental health crisis assessment is needed; and

(3) is assessed as experiencing a mental health crisis or emergency, and mental health crisis intervention or crisis intervention and stabilization services are determined to be medically necessary.

Subd. 4. **Provider entity standards.** (a) A provider entity is an entity that meets the standards listed in paragraph (b) and:

(1) is a county board operated entity; or

(2) is a provider entity that is under contract with the county board in the county where the potential crisis or emergency is occurring. To provide services under this section, the provider entity must directly provide the services; or if services are subcontracted, the provider entity must maintain responsibility for services and billing.

(b) The adult mental health crisis response services provider entity must meet the following standards:

(1) has the capacity to recruit, hire, and manage and train mental health professionals, practitioners, and rehabilitation workers;

(2) has adequate administrative ability to ensure availability of services;

(3) is able to ensure adequate preservice and in-service training;

(4) is able to ensure that staff providing these services are skilled in the delivery of mental health crisis response services to recipients;

(5) is able to ensure that staff are capable of implementing culturally specific treatment identified in the individual treatment plan that is meaningful and appropriate as determined by the recipient's culture, beliefs, values, and language;

(6) is able to ensure enough flexibility to respond to the changing intervention and care needs of a recipient as identified by the recipient during the service partnership between the recipient and providers;

(7) is able to ensure that mental health professionals and mental health practitioners have the communication tools and procedures to communicate and consult promptly about crisis assessment and interventions as services occur;

(8) is able to coordinate these services with county emergency services and mental health crisis services;

(9) is able to ensure that mental health crisis assessment and mobile crisis intervention services are available 24 hours a day, seven days a week;

(10) is able to ensure that services are coordinated with other mental health service providers, county mental health authorities, or federally recognized American Indian authorities and others as necessary, with the consent of the adult. Services must also be coordinated with the recipient's case manager if the adult is receiving case management services;

(11) is able to ensure that crisis intervention services are provided in a manner consistent with sections 245.461 to 245.486;

(12) is able to submit information as required by the state;

(13) maintains staff training and personnel files;

(14) is able to establish and maintain a quality assurance and evaluation plan to evaluate the outcomes of services and recipient satisfaction;

(15) is able to keep records as required by applicable laws;

(16) is able to comply with all applicable laws and statutes;

(17) is an enrolled medical assistance provider; and

(18) develops and maintains written policies and procedures regarding service provision and administration of the provider entity, including safety of staff and recipients in high-risk situations.

Subd. 5. **Mobile crisis intervention staff qualifications.** For provision of adult mental health mobile crisis intervention services, a mobile crisis intervention team is comprised of at least two mental health professionals as defined in section 245.462, subdivision 18, clauses (1) to (5), or a combination of at least one mental health professional and one mental health practitioner as defined in section 245.462, subdivision 17, with the required mental health crisis training and under the clinical supervision of a mental health professional on the team. The team must have at least two people with at least one member providing on-site crisis intervention services when needed. Team members must be experienced in mental health assessment, crisis intervention techniques, and clinical decision-making under emergency conditions and have knowledge of local services and resources. The team must recommend and coordinate the team's services with appropriate local resources such as the county social services agency, mental health services, and local law enforcement when necessary.

Subd. 6. **Initial screening, crisis assessment, and mobile intervention treatment planning.** (a) Prior to initiating mobile crisis intervention services, a screening of the potential crisis situation must be conducted. The screening may use the resources of crisis assistance and emergency services as defined in sections 245.462, subdivision 6, and 245.469, subdivisions 1 and 2. The screening must gather information, determine whether a crisis situation exists, identify parties involved, and determine an appropriate response.

(b) If a crisis exists, a crisis assessment must be completed. A crisis assessment evaluates any immediate needs for which emergency services are needed and, as time permits, the recipient's current life situation, sources of stress, mental health problems and symptoms, strengths, cultural considerations, support network, vulnerabilities, and current functioning.

(c) If the crisis assessment determines mobile crisis intervention services are needed, the intervention services must be provided promptly. As opportunity presents during the intervention, at least two members of the mobile crisis intervention team must confer directly or by telephone about the assessment, treatment plan, and actions taken and needed. At least one of the team members must be on site providing crisis intervention services. If providing on-site crisis intervention services, a mental health practitioner must seek clinical supervision as required in subdivision 9.

(d) The mobile crisis intervention team must develop an initial, brief crisis treatment plan as soon as appropriate but no later than 24 hours after the initial face-to-face intervention. The plan must address the needs and problems noted in the crisis assessment and include measurable short-term goals, cultural considerations, and frequency and type of services to be provided to achieve the goals and reduce or eliminate the crisis. The treatment plan must be updated as needed to reflect current goals and services.

(e) The team must document which short-term goals have been met and when no further crisis intervention services are required.

(f) If the recipient's crisis is stabilized, but the recipient needs a referral to other services, the team must provide referrals to these services. If the recipient has a case manager, planning for other services must be coordinated with the case manager.

Subd. 7. **Crisis stabilization services.** (a) Crisis stabilization services must be provided by qualified staff of a crisis stabilization services provider entity and must meet the following standards:

(1) a crisis stabilization treatment plan must be developed which meets the criteria in subdivision 11;

(2) staff must be qualified as defined in subdivision 8; and

(3) services must be delivered according to the treatment plan and include face-to-face contact with the recipient by qualified staff for further assessment, help with referrals, updating of the crisis stabilization treatment plan, supportive counseling, skills training, and collaboration with other service providers in the community.

(b) If crisis stabilization services are provided in a supervised, licensed residential setting, the recipient must be contacted face-to-face daily by a qualified mental health practitioner or mental health professional. The program must have 24-hour-a-day residential staffing which may include staff who do not meet the qualifications in subdivision 8. The residential staff must have 24-hour-a-day immediate direct or telephone access to a qualified mental health professional or practitioner.

(c) If crisis stabilization services are provided in a supervised, licensed residential setting that serves no more than four adult residents, and no more than two are recipients of crisis stabilization services, the residential staff must include, for at least eight hours per day, at least one individual who meets the qualifications in subdivision 8.

(d) If crisis stabilization services are provided in a supervised, licensed residential setting that serves more than four adult residents, and one or more are recipients of crisis stabilization services, the residential staff must include, for 24 hours a day, at least one individual who meets the qualifications in subdivision 8. During the first 48 hours that a recipient is in the residential program, the residential program must have at least two staff working 24 hours a day. Staffing levels may be adjusted thereafter according to the needs of the recipient as specified in the crisis stabilization treatment plan.

Subd. 8. **Adult crisis stabilization staff qualifications.** (a) Adult mental health crisis stabilization services must be provided by qualified individual staff of a qualified provider entity. Individual provider staff must have the following qualifications:

(1) be a mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (5);

(2) be a mental health practitioner as defined in section 245.462, subdivision 17. The mental health practitioner must work under the clinical supervision of a mental health professional; or

(3) be a mental health rehabilitation worker who meets the criteria in section 256B.0623, subdivision 5, clause (3); works under the direction of a mental health practitioner as defined in section 245.462, subdivision 17, or under direction of a mental health professional; and works under the clinical supervision of a mental health professional.

(b) Mental health practitioners and mental health rehabilitation workers must have completed at least 30 hours of training in crisis intervention and stabilization during the past two years.

Subd. 9. **Supervision.** Mental health practitioners may provide crisis assessment and mobile crisis intervention services if the following clinical supervision requirements are met:

(1) the mental health provider entity must accept full responsibility for the services provided;

(2) the mental health professional of the provider entity, who is an employee or under contract with the provider entity, must be immediately available by phone or in person for clinical supervision;

(3) the mental health professional is consulted, in person or by phone, during the first three hours when a mental health practitioner provides on-site service;

(4) the mental health professional must:

(i) review and approve of the tentative crisis assessment and crisis treatment plan;

(ii) document the consultation; and

(iii) sign the crisis assessment and treatment plan within the next business day;

(5) if the mobile crisis intervention services continue into a second calendar day, a mental health professional must contact the recipient face-to-face on the second day to provide services and update the crisis treatment plan; and

(6) the on-site observation must be documented in the recipient's record and signed by the mental health professional.

Subd. 10. **Recipient file.** Providers of mobile crisis intervention or crisis stabilization services must maintain a file for each recipient containing the following information:

(1) individual crisis treatment plans signed by the recipient, mental health professional, and mental health practitioner who developed the crisis treatment plan, or if the recipient refused to sign the plan, the date and reason stated by the recipient as to why the recipient would not sign the plan;

(2) signed release forms;

(3) recipient health information and current medications;

(4) emergency contacts for the recipient;

(5) case records which document the date of service, place of service delivery, signature of the person providing the service, and the nature, extent, and units of service. Direct or telephone contact with the recipient's family or others should be documented;

(6) required clinical supervision by mental health professionals;

(7) summary of the recipient's case reviews by staff; and

(8) any written information by the recipient that the recipient wants in the file.

Documentation in the file must comply with all requirements of the commissioner.

Subd. 11. **Treatment plan.** The individual crisis stabilization treatment plan must include, at a minimum:

(1) a list of problems identified in the assessment;

(2) a list of the recipient's strengths and resources;

(3) concrete, measurable short-term goals and tasks to be achieved, including time frames for achievement;

(4) specific objectives directed toward the achievement of each one of the goals;

(5) documentation of the participants involved in the service planning. The recipient, if possible, must be a participant. The recipient or the recipient's legal guardian must sign the service plan or documentation must be provided why this was not possible. A copy of the plan must be given to the recipient and the recipient's legal guardian. The plan should include services arranged, including specific providers where applicable;

(6) planned frequency and type of services initiated;

(7) a crisis response action plan if a crisis should occur;

(8) clear progress notes on outcome of goals;

(9) a written plan must be completed within 24 hours of beginning services with the recipient; and

(10) a treatment plan must be developed by a mental health professional or mental health practitioner under the clinical supervision of a mental health professional. The mental health professional must approve and sign all treatment plans.

Subd. 12. **Excluded services.** The following services are excluded from reimbursement under this section:

(1) room and board services;

(2) services delivered to a recipient while admitted to an inpatient hospital;

(3) recipient transportation costs may be covered under other medical assistance provisions, but transportation services are not an adult mental health crisis response service;

(4) services provided and billed by a provider who is not enrolled under medical assistance to provide adult mental health crisis response services;

(5) services performed by volunteers;

(6) direct billing of time spent "on call" when not delivering services to a recipient;

(7) provider service time included in case management reimbursement. When a provider is eligible to provide more than one type of medical assistance service, the recipient must have a choice of provider for each service, unless otherwise provided for by law;

(8) outreach services to potential recipients; and

(9) a mental health service that is not medically necessary.

History: *1Sp2001 c 9 art 9 s 40*

256B.0625 COVERED SERVICES.

[For text of subds 1 to 3a, see M.S.2000]

Subd. 3b. **Telemedicine consultations.** Medical assistance covers telemedicine consultations. Telemedicine consultations must be made via two-way, interactive video or store-and-forward technology. Store-and-forward technology includes telemedicine consultations that do not occur in real time via synchronous transmissions, and that do not require a face-to-face encounter with the patient for all or any part of any such telemedicine consultation. The patient record must include a written opinion from the consulting physician providing the telemedicine consultation. A communication between two physicians that consists solely of a telephone conversation is not a telemedicine consultation. Coverage is limited to three telemedicine consultations per recipient per calendar week. Telemedicine consultations shall be paid at the full allowable rate.

[For text of subds 4 to 5, see M.S.2000]

Subd. 5a. **Intensive early intervention behavior therapy services for children with autism spectrum disorders.** (a) **Coverage.** Medical assistance covers home-based intensive early intervention behavior therapy for children with autism spectrum disorders. Children with autism spectrum disorder, and their custodial parents or foster parents, may access other covered services to treat autism spectrum disorder, and are not required to receive intensive early intervention behavior therapy services under this subdivision. Intensive early intervention behavior therapy does not include coverage for services to treat developmental disorders of language, early onset psychosis, Rett's disorder, selective mutism, social anxiety disorder, stereotypic movement disorder, dementia, obsessive compulsive disorder, schizoid personality disorder, avoidant personality disorder, or reactive attachment disorder. If a child with autism spectrum disorder is diagnosed to have one or more of these conditions, intensive early intervention behavior therapy includes coverage only for services necessary to treat the autism spectrum disorder.

(b) **Purpose of intensive early intervention behavior therapy services (IEIBTS).** The purpose of IEIBTS is to improve the child's behavioral functioning, to prevent development of challenging behaviors, to eliminate autistic behaviors, to reduce the risk of out-of-home placement, and to establish independent typical functioning in language and social behavior. The procedures used to accomplish these goals are based upon research in applied behavior analysis.

(c) **Eligible children.** A child is eligible to initiate IEIBTS if, the child meets the additional eligibility criteria in paragraph (d) and in a diagnostic assessment by a mental health professional who is not under the employ of the service provider, the child:

(1) is found to have an autism spectrum disorder;

(2) has a current IQ of either untestable, or at least 30;

(3) if nonverbal, initiated behavior therapy by 42 months of age;

(4) if verbal, initiated behavior therapy by 48 months of age; or

(5) if having an IQ of at least 50, initiated behavior therapy by 84 months of age.

To continue after six-month individualized treatment plan (ITP) reviews, at least one of the child's custodial parents or foster parents must participate in an average of at least five hours of documented behavior therapy per week for six months, and consistently implement behavior therapy recommendations 24 hours a day. To continue after six-month individualized treatment plan (ITP) reviews, the child must show documented progress toward mastery of six-month benchmark behavior objectives. The maximum number of months during which services may be billed is 54, or up to the month of August in the first year in which the child completes first grade, whichever comes last. If significant progress towards treatment goals has not been achieved after 24 months of treatment, treatment must be discontinued.

(d) **Additional eligibility criteria.** A child is eligible to initiate IEIBTS if:

(1) in medical and diagnostic assessments by medical and mental health professionals, it is determined that the child does not have severe or profound mental retardation;

(2) an accurate assessment of the child's hearing has been performed, including audiometry if the brain stem auditory evokes response;

(3) a blood lead test has been performed prior to initiation of treatment; and

(4) an EEG or neurologic evaluation is done, prior to initiation of treatment, if the child has a history of staring spells or developmental regression.

(e) **Covered services.** The focus of IEIBTS must be to treat the principal diagnostic features of the autism spectrum disorder. All IEIBTS must be delivered by a team of practitioners under the consistent supervision of a single clinical supervisor. A mental health professional must develop the ITP for IEIBTS. The ITP must include six-month benchmark behavior objectives. All behavior therapy must be based upon research in applied behavior analysis, with an emphasis upon positive reinforcement of carefully task-analyzed skills for optimum rates of progress. All behavior therapy must be consistently applied and generalized throughout the 24-hour day and seven-day week by all of the child's regular care providers. When placing the child in school activities, a majority of the peers must have no mental health diagnosis, and the child must have sufficient social skills to succeed with 80 percent of the school activities. Reactive consequences, such as redirection, correction, positive practice, or time-out, must be used only when necessary to improve the child's success when proactive procedures alone have not been effective. IEIBTS must be delivered by a team of behavior therapy practitioners who are employed under the direction of the same agency. The team may deliver up to 200 billable hours per year of direct clinical supervisor services, up to 700 billable hours per year of senior behavior therapist services, and up to 1,800 billable hours per year of direct behavior therapist services. A one-hour clinical review meeting for the child, parents, and staff must be scheduled 50 weeks a year, at which behavior therapy is reviewed and planned. At least one-quarter of the annual clinical supervisor billable hours shall consist of on-site clinical meeting time. At least one-half of the annual senior behavior therapist billable hours shall consist of direct services to the child or parents. All of the behavioral therapist billable hours shall consist of direct on-site services to the child or parents. None of the senior behavior therapist billable hours or behavior therapist billable hours shall consist of clinical meeting time. If there is any regression of the autistic spectrum disorder after 12 months of therapy, a neurologic consultation must be performed.

(f) **Provider qualifications.** The provider agency must be capable of delivering consistent applied behavior analysis (ABA) based behavior therapy in the home. The site director of the agency must be a mental health professional and a board certified behavior analyst certified by the behavior analyst certification board. Each clinical supervisor must be a certified associate behavior analyst certified by the behavior analyst certification board or have equivalent experience in applied behavior analysis.

(g) **Supervision requirements.** (1) Each behavior therapist practitioner must be continuously supervised while in the home until the practitioner has mastered compe-

tencies for independent practice. Each behavior therapist must have mastered three credits of academic content and practice in an applied behavior analysis sequence at an accredited university before providing more than 12 months of therapy. A college degree or minimum hours of experience are not required. Each behavior therapist must continue training through weekly direct observation by the senior behavior therapist, through demonstrated performance in clinical meetings with the clinical supervisor, and annual training in applied behavior analysis.

(2) Each senior behavior therapist practitioner must have mastered the senior behavior therapy competencies, completed one year of practice as a behavior therapist, and six months of co-therapy training with another senior behavior therapist or have an equivalent amount of experience in applied behavior analysis. Each senior behavior therapist must have mastered 12 credits of academic content and practice in an applied behavior analysis sequence at an accredited university before providing more than 12 months of senior behavior therapy. Each senior behavior therapist must continue training through demonstrated performance in clinical meetings with the clinical supervisor, and annual training in applied behavior analysis.

(3) Each clinical supervisor practitioner must have mastered the clinical supervisor and family consultation competencies, completed two years of practice as a senior behavior therapist and one year of co-therapy training with another clinical supervisor, or equivalent experience in applied behavior analysis. Each clinical supervisor must continue training through annual training in applied behavior analysis.

(h) **Place of service.** IEIBTS are provided primarily in the child's home and community. Services may be provided in the child's natural school or preschool classroom, home of a relative, natural recreational setting, or day care.

(i) **Prior authorization requirements.** Prior authorization shall be required for services provided after 200 hours of clinical supervisor, 700 hours of senior behavior therapist, or 1,800 hours of behavior therapist services per year.

(j) **Payment rates.** The following payment rates apply:

(1) for an IEIBTS clinical supervisor practitioner under supervision of a mental health professional, the lower of the submitted charge or $67 per hour unit;

(2) for an IEIBTS senior behavior therapist practitioner under supervision of a mental health professional, the lower of the submitted charge or $37 per hour unit; or

(3) for an IEIBTS behavior therapist practitioner under supervision of a mental health professional, the lower of the submitted charge or $27 per hour unit.

An IEIBTS practitioner may receive payment for travel time which exceeds 50 minutes one-way. The maximum payment allowed will be $0.51 per minute for up to a maximum of 300 hours per year.

For any week during which the above charges are made to medical assistance, payments for the following services are excluded: supervising mental health professional hours and personal care attendant, home-based mental health, family-community support, or mental health behavioral aide hours.

(k) **Report.** The commissioner shall collect evidence of the effectiveness of intensive early intervention behavior therapy services and present a report to the legislature by July 1, 2006.

[For text of subd 6a, see M.S.2000]

Subd. 7. **Private duty nursing.** Medical assistance covers private duty nursing services in a recipient's home. Recipients who are authorized to receive private duty nursing services in their home may use approved hours outside of the home during hours when normal life activities take them outside of their home. To use private duty nursing services at school, the recipient or responsible party must provide written authorization in the care plan identifying the chosen provider and the daily amount of services to be used at school. Medical assistance does not cover private duty nursing services for residents of a hospital, nursing facility, intermediate care facility, or a health care facility licensed by the commissioner of health, except as authorized in

section 256B.64 for ventilator-dependent recipients in hospitals or unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the private duty nursing services or forgoes the facility per diem for the leave days that private duty nursing services are used. Total hours of service and payment allowed for services outside the home cannot exceed that which is otherwise allowed in an in-home setting according to section 256B.0627. All private duty nursing services must be provided according to the limits established under section 256B.0627. Private duty nursing services may not be reimbursed if the nurse is the foster care provider of a recipient who is under age 18.

[For text of subds 8 to 8c, see M.S.2000]

Subd. 9. **Dental services.** Medical assistance covers dental services. Dental services include, with prior authorization, fixed bridges that are cost-effective for persons who cannot use removable dentures because of their medical condition.

[For text of subds 10 to 12, see M.S.2000]

Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs when specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed by a licensed pharmacist, by a physician enrolled in the medical assistance program as a dispensing physician, or by a physician or a nurse practitioner employed by or under contract with a community health board as defined in section 145A.02, subdivision 5, for the purposes of communicable disease control. The commissioner, after receiving recommendations from professional medical associations and professional pharmacist associations, shall designate a formulary committee to advise the commissioner on the names of drugs for which payment is made, recommend a system for reimbursing providers on a set fee or charge basis rather than the present system, and develop methods encouraging use of generic drugs when they are less expensive and equally effective as trademark drugs. The formulary committee shall consist of nine members, four of whom shall be physicians who are not employed by the department of human services, and a majority of whose practice is for persons paying privately or through health insurance, three of whom shall be pharmacists who are not employed by the department of human services, and a majority of whose practice is for persons paying privately or through health insurance, a consumer representative, and a nursing home representative. Committee members shall serve three-year terms and shall serve without compensation. Members may be reappointed once.

(b) The commissioner shall establish a drug formulary. Its establishment and publication shall not be subject to the requirements of the Administrative Procedure Act, but the formulary committee shall review and comment on the formulary contents. The formulary committee shall review and recommend drugs which require prior authorization. The formulary committee may recommend drugs for prior authorization directly to the commissioner, as long as opportunity for public input is provided. Prior authorization may be requested by the commissioner based on medical and clinical criteria before certain drugs are eligible for payment. Before a drug may be considered for prior authorization at the request of the commissioner:

(1) the drug formulary committee must develop criteria to be used for identifying drugs; the development of these criteria is not subject to the requirements of chapter 14, but the formulary committee shall provide opportunity for public input in developing criteria;

(2) the drug formulary committee must hold a public forum and receive public comment for an additional 15 days; and

(3) the commissioner must provide information to the formulary committee on the impact that placing the drug on prior authorization will have on the quality of patient care and information regarding whether the drug is subject to clinical abuse or misuse. Prior authorization may be required by the commissioner before certain formulary drugs are eligible for payment. The formulary shall not include:

(i) drugs or products for which there is no federal funding;

(ii) over-the-counter drugs, except for antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, vitamins for children under the age of seven and pregnant or nursing women, and any other over-the-counter drug identified by the commissioner, in consultation with the drug formulary committee, as necessary, appropriate, and cost-effective for the treatment of certain specified chronic diseases, conditions or disorders, and this determination shall not be subject to the requirements of chapter 14;

(iii) anorectics, except that medically necessary anorectics shall be covered for a recipient previously diagnosed as having pickwickian syndrome and currently diagnosed as having diabetes and being morbidly obese;

(iv) drugs for which medical value has not been established; and

(v) drugs from manufacturers who have not signed a rebate agreement with the Department of Health and Human Services pursuant to section 1927 of title XIX of the Social Security Act.

The commissioner shall publish conditions for prohibiting payment for specific drugs after considering the formulary committee's recommendations. An honorarium of $100 per meeting and reimbursement for mileage shall be paid to each committee member in attendance.

(c) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs plus a fixed dispensing fee; the maximum allowable cost set by the federal government or by the commissioner plus the fixed dispensing fee; or the usual and customary price charged to the public. The pharmacy dispensing fee shall be $3.65, except that the dispensing fee for intravenous solutions which must be compounded by the pharmacist shall be $8 per bag, $14 per bag for cancer chemotherapy products, and $30 per bag for total parenteral nutritional products dispensed in one liter quantities, or $44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. The actual acquisition cost of a drug shall be estimated by the commissioner, at average wholesale price minus nine percent, except that where a drug has had its wholesale price reduced as a result of the actions of the National Association of Medicaid Fraud Control Units, the estimated actual acquisition cost shall be the reduced average wholesale price, without the nine percent deduction. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, the maximum amount paid by other third-party payors in this state who have maximum allowable cost programs. The commissioner shall set maximum allowable costs for multisource drugs that are not on the federal upper limit list as described in United States Code, title 42, chapter 7, section 1396r-8(e), the Social Security Act, and Code of Federal Regulations, title 42, part 447, section 447.332. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act. An additional dispensing fee of $.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider will be required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse. Over-the-counter medications must be dispensed in the manufacturer's unopened package. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply. Whenever a generically equivalent product is available, payment shall be on the basis of the actual acquisition cost of the generic drug, unless the prescriber specifically indicates "dispense as written - brand necessary" on the prescription as required by section 151.21, subdivision 2.

(d) For purposes of this subdivision, "multisource drugs" means covered outpatient drugs, excluding innovator multisource drugs for which there are two or more drug products, which:

(1) are related as therapeutically equivalent under the Food and Drug Administration's most recent publication of "Approved Drug Products with Therapeutic Equivalence Evaluations";

(2) are pharmaceutically equivalent and bioequivalent as determined by the Food and Drug Administration; and

(3) are sold or marketed in Minnesota.

"Innovator multisource drug" means a multisource drug that was originally marketed under an original new drug application approved by the Food and Drug Administration.

(e) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider; the average wholesale price minus five percent; or the maximum allowable cost set by the federal government under United States Code, title 42, chapter 7, section 1396r-8(e), and Code of Federal Regulations, title 42, section 447.332, or by the commissioner under paragraph (c).

Subd. 13a. **Drug utilization review board.** A nine-member drug utilization review board is established. The board is comprised of at least three but no more than four licensed physicians actively engaged in the practice of medicine in Minnesota; at least three licensed pharmacists actively engaged in the practice of pharmacy in Minnesota; and one consumer representative; the remainder to be made up of health care professionals who are licensed in their field and have recognized knowledge in the clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs. The board shall be staffed by an employee of the department who shall serve as an ex officio nonvoting member of the board. The members of the board shall be appointed by the commissioner and shall serve three-year terms. The members shall be selected from lists submitted by professional associations. The commissioner shall appoint the initial members of the board for terms expiring as follows: three members for terms expiring June 30, 1996; three members for terms expiring June 30, 1997; and three members for terms expiring June 30, 1998. Members may be reappointed once. The board shall annually elect a chair from among the members.

The commissioner shall, with the advice of the board:

(1) implement a medical assistance retrospective and prospective drug utilization review program as required by United States Code, title 42, section 1396r-8(g)(3);

(2) develop and implement the predetermined criteria and practice parameters for appropriate prescribing to be used in retrospective and prospective drug utilization review;

(3) develop, select, implement, and assess interventions for physicians, pharmacists, and patients that are educational and not punitive in nature;

(4) establish a grievance and appeals process for physicians and pharmacists under this section;

(5) publish and disseminate educational information to physicians and pharmacists regarding the board and the review program;

(6) adopt and implement procedures designed to ensure the confidentiality of any information collected, stored, retrieved, assessed, or analyzed by the board, staff to the board, or contractors to the review program that identifies individual physicians, pharmacists, or recipients;

(7) establish and implement an ongoing process to (i) receive public comment regarding drug utilization review criteria and standards, and (ii) consider the comments along with other scientific and clinical information in order to revise criteria and standards on a timely basis; and

(8) adopt any rules necessary to carry out this section.

The board may establish advisory committees. The commissioner may contract with appropriate organizations to assist the board in carrying out the board's duties. The commissioner may enter into contracts for services to develop and implement a retrospective and prospective review program.

The board shall report to the commissioner annually on the date the Drug Utilization Review Annual Report is due to the Health Care Financing Administration. This report is to cover the preceding federal fiscal year. The commissioner shall make the report available to the public upon request. The report must include information on the activities of the board and the program; the effectiveness of implemented interventions; administrative costs; and any fiscal impact resulting from the program. An honorarium of $100 per meeting and reimbursement for mileage shall be paid to each board member in attendance.

[For text of subds 14 to 16, see M.S.2000]

Subd. 17. **Transportation costs.** (a) Medical assistance covers transportation costs incurred solely for obtaining emergency medical care or transportation costs incurred by nonambulatory persons in obtaining emergency or nonemergency medical care when paid directly to an ambulance company, common carrier, or other recognized providers of transportation services. For the purpose of this subdivision, a person who is incapable of transport by taxicab or bus shall be considered to be nonambulatory.

(b) Medical assistance covers special transportation, as defined in Minnesota Rules, part 9505.0315, subpart 1, item F, if the provider receives and maintains a current physician's order by the recipient's attending physician certifying that the recipient has a physical or mental impairment that would prohibit the recipient from safely accessing and using a bus, taxi, other commercial transportation, or private automobile. Special transportation includes driver-assisted service to eligible individuals. Driver-assisted service includes passenger pickup at and return to the individual's residence or place of business, assistance with admittance of the individual to the medical facility, and assistance in passenger securement or in securing of wheelchairs or stretchers in the vehicle. The commissioner shall establish maximum medical assistance reimbursement rates for special transportation services for persons who need a wheelchair-accessible van or stretcher-accessible vehicle and for those who do not need a wheelchair-accessible van or stretcher-accessible vehicle. The average of these two rates per trip must not exceed $15 for the base rate and $1.40 per mile. Special transportation provided to nonambulatory persons who do not need a wheelchair-accessible van or stretcher-accessible vehicle, may be reimbursed at a lower rate than special transportation provided to persons who need a wheelchair-accessible van or stretcher-accessible vehicle.

Subd. 17a. **Payment for ambulance services.** Effective for services rendered on or after July 1, 2001, medical assistance payments for ambulance services shall be paid at the Medicare reimbursement rate or at the medical assistance payment rate in effect on July 1, 2000, whichever is greater.

[For text of subd 18, see M.S.2000]

Subd. 18a. **Access to medical services.** (a) Medical assistance reimbursement for meals for persons traveling to receive medical care may not exceed $5.50 for breakfast, $6.50 for lunch, or $8 for dinner.

(b) Medical assistance reimbursement for lodging for persons traveling to receive medical care may not exceed $50 per day unless prior authorized by the local agency.

(c) Medical assistance direct mileage reimbursement to the eligible person or the eligible person's driver may not exceed 20 cents per mile.

(d) Medical assistance covers oral language interpreter services when provided by an enrolled health care provider during the course of providing a direct, person-to-person covered health care service to an enrolled recipient with limited English proficiency.

Subd. 19a. **Personal care assistant services.** Medical assistance covers personal care assistant services in a recipient's home. To qualify for personal care assistant services, recipients or responsible parties must be able to identify the recipient's needs, direct and evaluate task accomplishment, and provide for health and safety. Approved hours may be used outside the home when normal life activities take them outside the home. To use personal care assistant services at school, the recipient or responsible party must provide written authorization in the care plan identifying the chosen provider and the daily amount of services to be used at school. Total hours for services, whether actually performed inside or outside the recipient's home, cannot exceed that which is otherwise allowed for personal care assistant services in an in-home setting according to section 256B.0627. Medical assistance does not cover personal care assistant services for residents of a hospital, nursing facility, intermediate care facility, health care facility licensed by the commissioner of health, or unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the personal care assistant services or forgoes the facility per diem for the leave days that personal care assistant services are used. All personal care assistant services must be provided according to section 256B.0627. Personal care assistant services may not be reimbursed if the personal care assistant is the spouse or legal guardian of the recipient or the parent of a recipient under age 18, or the responsible party or the foster care provider of a recipient who cannot direct the recipient's own care unless, in the case of a foster care provider, a county or state case manager visits the recipient as needed, but not less than every six months, to monitor the health and safety of the recipient and to ensure the goals of the care plan are met. Parents of adult recipients, adult children of the recipient or adult siblings of the recipient may be reimbursed for personal care assistant services, if they are granted a waiver under section 256B.0627. Notwithstanding the provisions of section 256B.0627, subdivision 4, paragraph (b), clause (4), the noncorporate legal guardian or conservator of an adult, who is not the responsible party and not the personal care provider organization, may be granted a hardship waiver under section 256B.0627, to be reimbursed to provide personal care assistant services to the recipient, and shall not be considered to have a service provider interest for purposes of participation on the screening team under section 256B.092, subdivision 7.

[For text of subd 19b, see M.S.2000]

Subd. 19c. **Personal care.** Medical assistance covers personal care assistant services provided by an individual who is qualified to provide the services according to subdivision 19a and section 256B.0627, where the services are prescribed by a physician in accordance with a plan of treatment and are supervised by the recipient or a qualified professional. "Qualified professional" means a mental health professional as defined in section 245.462, subdivision 18, or 245.4871, subdivision 27; or a registered nurse as defined in sections 148.171 to 148.285. As part of the assessment, the county public health nurse will assist the recipient or responsible party to identify the most appropriate person to provide supervision of the personal care assistant. The qualified professional shall perform the duties described in Minnesota Rules, part 9505.0335, subpart 4.

Subd. 20. **Mental health case management.** (a) To the extent authorized by rule of the state agency, medical assistance covers case management services to persons with serious and persistent mental illness and children with severe emotional disturbance. Services provided under this section must meet the relevant standards in sections 245.461 to 245.4888, the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

(b) Entities meeting program standards set out in rules governing family community support services as defined in section 245.4871, subdivision 17, are eligible for medical assistance reimbursement for case management services for children with severe emotional disturbance when these services meet the program standards in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

(c) Medical assistance and MinnesotaCare payment for mental health case management shall be made on a monthly basis. In order to receive payment for an eligible child, the provider must document at least a face-to-face contact with the child, the child's parents, or the child's legal representative. To receive payment for an eligible adult, the provider must document:

(1) at least a face-to-face contact with the adult or the adult's legal representative; or

(2) at least a telephone contact with the adult or the adult's legal representative and document a face-to-face contact with the adult or the adult's legal representative within the preceding two months.

(d) Payment for mental health case management provided by county or state staff shall be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph (b), with separate rates calculated for child welfare and mental health, and within mental health, separate rates for children and adults.

(e) Payment for mental health case management provided by Indian health services or by agencies operated by Indian tribes may be made according to this section or other relevant federally approved rate setting methodology.

(f) Payment for mental health case management provided by vendors who contract with a county or Indian tribe shall be based on a monthly rate negotiated by the host county or tribe. The negotiated rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the county or tribe may negotiate a team rate with a vendor who is a member of the team. The team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county or tribe, except to reimburse the county or tribe for advance funding provided by the county or tribe to the vendor.

(g) If the service is provided by a team which includes contracted vendors, tribal staff, and county or state staff, the costs for county or state staff participation in the team shall be included in the rate for county-provided services. In this case, the contracted vendor, the tribal agency, and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, each entity must document, in the recipient's file, the need for team case management and a description of the roles of the team members.

(h) The commissioner shall calculate the nonfederal share of actual medical assistance and general assistance medical care payments for each county, based on the higher of calendar year 1995 or 1996, by service date, project that amount forward to 1999, and transfer one-half of the result from medical assistance and general assistance medical care to each county's mental health grants under sections 245.4886 and 256E.12 for calendar year 1999. The annualized minimum amount added to each county's mental health grant shall be $3,000 per year for children and $5,000 per year for adults. The commissioner may reduce the statewide growth factor in order to fund these minimums. The annualized total amount transferred shall become part of the base for future mental health grants for each county.

(i) Any net increase in revenue to the county or tribe as a result of the change in this section must be used to provide expanded mental health services as defined in sections 245.461 to 245.4888, the Comprehensive Adult and Children's Mental Health Acts, excluding inpatient and residential treatment. For adults, increased revenue may also be used for services and consumer supports which are part of adult mental health projects approved under Laws 1997, chapter 203, article 7, section 25. For children, increased revenue may also be used for respite care and nonresidential individualized rehabilitation services as defined in section 245.492, subdivisions 17 and 23. "Increased revenue" has the meaning given in Minnesota Rules, part 9520.0903, subpart 3.

(j) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for mental health case management shall be provided by the recipient's county of responsibility, as defined in sections 256G.01 to 256G.12, from sources other than

federal funds or funds used to match other federal funds. If the service is provided by a tribal agency, the nonfederal share, if any, shall be provided by the recipient's tribe.

(k) The commissioner may suspend, reduce, or terminate the reimbursement to a provider that does not meet the reporting or other requirements of this section. The county of responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the tribal agency, is responsible for any federal disallowances. The county or tribe may share this responsibility with its contracted vendors.

(l) The commissioner shall set aside a portion of the federal funds earned under this section to repay the special revenue maximization account under section 256.01, subdivision 2, clause (15). The repayment is limited to:

(1) the costs of developing and implementing this section; and

(2) programming the information systems.

(m) Notwithstanding section 256.025, subdivision 2, payments to counties and tribal agencies for case management expenditures under this section shall only be made from federal earnings from services provided under this section. Payments to county-contracted vendors shall include both the federal earnings and the county share.

(n) Notwithstanding section 256B.041, county payments for the cost of mental health case management services provided by county or state staff shall not be made to the state treasurer. For the purposes of mental health case management services provided by county or state staff under this section, the centralized disbursement of payments to counties under section 256B.041 consists only of federal earnings from services provided under this section.

(o) Case management services under this subdivision do not include therapy, treatment, legal, or outreach services.

(p) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital, and the recipient's institutional care is paid by medical assistance, payment for case management services under this subdivision is limited to the last 180 days of the recipient's residency in that facility and may not exceed more than six months in a calendar year.

(q) Payment for case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

(r) By July 1, 2000, the commissioner shall evaluate the effectiveness of the changes required by this section, including changes in number of persons receiving mental health case management, changes in hours of service per person, and changes in caseload size.

(s) For each calendar year beginning with the calendar year 2001, the annualized amount of state funds for each county determined under paragraph (h) shall be adjusted by the county's percentage change in the average number of clients per month who received case management under this section during the fiscal year that ended six months prior to the calendar year in question, in comparison to the prior fiscal year.

(t) For counties receiving the minimum allocation of $3,000 or $5,000 described in paragraph (h), the adjustment in paragraph (s) shall be determined so that the county receives the higher of the following amounts:

(1) a continuation of the minimum allocation in paragraph (h); or

(2) an amount based on that county's average number of clients per month who received case management under this section during the fiscal year that ended six months prior to the calendar year in question, times the average statewide grant per person per month for counties not receiving the minimum allocation.

(u) The adjustments in paragraphs (s) and (t) shall be calculated separately for children and adults.

[For text of subds 20a to 29, see M.S.2000]

Subd. 30. **Other clinic services.** (a) Medical assistance covers rural health clinic services, federally qualified health center services, nonprofit community health clinic services, public health clinic services, and the services of a clinic meeting the criteria

established in rule by the commissioner. Rural health clinic services and federally qualified health center services mean services defined in United States Code, title 42, section 1396d(a)(2)(B) and (C). Payment for rural health clinic and federally qualified health center services shall be made according to applicable federal law and regulation.

(b) A federally qualified health center that is beginning initial operation shall submit an estimate of budgeted costs and visits for the initial reporting period in the form and detail required by the commissioner. A federally qualified health center that is already in operation shall submit an initial report using actual costs and visits for the initial reporting period. Within 90 days of the end of its reporting period, a federally qualified health center shall submit, in the form and detail required by the commissioner, a report of its operations, including allowable costs actually incurred for the period and the actual number of visits for services furnished during the period, and other information required by the commissioner. Federally qualified health centers that file Medicare cost reports shall provide the commissioner with a copy of the most recent Medicare cost report filed with the Medicare program intermediary for the reporting year which support the costs claimed on their cost report to the state.

(c) In order to continue cost-based payment under the medical assistance program according to paragraphs (a) and (b), a federally qualified health center or rural health clinic must apply for designation as an essential community provider within six months of final adoption of rules by the department of health according to section 62Q.19, subdivision 7. For those federally qualified health centers and rural health clinics that have applied for essential community provider status within the six-month time prescribed, medical assistance payments will continue to be made according to paragraphs (a) and (b) for the first three years after application. For federally qualified health centers and rural health clinics that either do not apply within the time specified above or who have had essential community provider status for three years, medical assistance payments for health services provided by these entities shall be according to the same rates and conditions applicable to the same service provided by health care providers that are not federally qualified health centers or rural health clinics.

(d) Effective July 1, 1999, the provisions of paragraph (c) requiring a federally qualified health center or a rural health clinic to make application for an essential community provider designation in order to have cost-based payments made according to paragraphs (a) and (b) no longer apply.

(e) Effective January 1, 2000, payments made according to paragraphs (a) and (b) shall be limited to the cost phase-out schedule of the Balanced Budget Act of 1997.

(f) Effective January 1, 2001, each federally qualified health center and rural health clinic may elect to be paid either under the prospective payment system established in United States Code, title 42, section 1396a(aa), or under an alternative payment methodology consistent with the requirements of United States Code, title 42, section 1396a(aa), and approved by the Health Care Financing Administration. The alternative payment methodology shall be 100 percent of cost as determined according to Medicare cost principles.

[For text of subds 31 and 32, see M.S.2000]

Subd. 33. **Child welfare targeted case management.** Medical assistance, subject to federal approval, covers child welfare targeted case management services as defined in section 256B.094 to children under age 21 who have been assessed and determined in accordance with section 256F.095 to be:

(1) at risk of placement or in placement as defined in section 260C.212, subdivision 1;

(2) at risk of maltreatment or experiencing maltreatment as defined in section 626.556, subdivision 10e; or

(3) in need of protection or services as defined in section 260C.007, subdivision 6.

Subd. 34. **Indian health services facilities.** Medical assistance payments and MinnesotaCare payments to facilities of the Indian health service and facilities operated by a tribe or tribal organization under funding authorized by United States Code,

title 25, sections 450f to 450n, or title III of the Indian Self-Determination and Education Assistance Act, Public Law Number 93-638, for enrollees who are eligible for federal financial participation, shall be at the option of the facility in accordance with the rate published by the United States Assistant Secretary for Health under the authority of United States Code, title 42, sections 248(a) and 249(b). General assistance medical care payments to facilities of the Indian health services and facilities operated by a tribe or tribal organization for the provision of outpatient medical care services billed after June 30, 1990, must be in accordance with the general assistance medical care rates paid for the same services when provided in a facility other than a facility of the Indian health service or a facility operated by a tribe or tribal organization. MinnesotaCare payments for enrollees who are not eligible for federal financial participation at facilities of the Indian health service and facilities operated by a tribe or tribal organization for the provision of outpatient medical services must be in accordance with the medical assistance rates paid for the same services when provided in a facility other than a facility of the Indian health service or a facility operated by a tribe or tribal organization.

[For text of subds 35 to 42, see M.S.2000]

Subd. 43. **Mental health provider travel time.** Medical assistance covers provider travel time if a recipient's individual treatment plan requires the provision of mental health services outside of the provider's normal place of business. This does not include any travel time which is included in other billable services, and is only covered when the mental health service being provided to a recipient is covered under medical assistance.

History: *2001 c 178 art 1 s 44; 2001 c 203 s 9; 1Sp2001 c 9 art 2 s 30-38; art 3 s 16-19; art 9 s 41,42*

NOTE: Subdivision 5a, as added by Laws 2001, First Special Session chapter 9, article 2, section 31, is effective January 1, 2003. Laws 2001, First Special Session chapter 9, article 2, section 31, the effective date.

256B.0627 COVERED SERVICE; HOME CARE SERVICES.

Subdivision 1. **Definition.** (a) "Activities of daily living" includes eating, toileting, grooming, dressing, bathing, transferring, mobility, and positioning.

(b) "Assessment" means a review and evaluation of a recipient's need for home care services conducted in person. Assessments for private duty nursing shall be conducted by a registered private duty nurse. Assessments for home health agency services shall be conducted by a home health agency nurse. Assessments for personal care assistant services shall be conducted by the county public health nurse or a certified public health nurse under contract with the county. A face-to-face assessment must include: documentation of health status, determination of need, evaluation of service effectiveness, identification of appropriate services, service plan development or modification, coordination of services, referrals and follow-up to appropriate payers and community resources, completion of required reports, recommendation of service authorization, and consumer education. Once the need for personal care assistant services is determined under this section, the county public health nurse or certified public health nurse under contract with the county is responsible for communicating this recommendation to the commissioner and the recipient. A face-to-face assessment for personal care assistant services is conducted on those recipients who have never had a county public health nurse assessment. A face-to-face assessment must occur at least annually or when there is a significant change in the recipient's condition or when there is a change in the need for personal care assistant services. A service update may substitute for the annual face-to-face assessment when there is not a significant change in recipient condition or a change in the need for personal care assistant service. A service update or review for temporary increase includes a review of initial baseline data, evaluation of service effectiveness, redetermination of service need, modification of service plan and appropriate referrals, update of initial forms, obtaining service authorization, and on going consumer education. Assessments for medical assistance home care services for mental retardation or related conditions and alternative care

services for developmentally disabled home and community-based waivered recipients may be conducted by the county public health nurse to ensure coordination and avoid duplication. Assessments must be completed on forms provided by the commissioner within 30 days of a request for home care services by a recipient or responsible party.

(c) "Care plan" means a written description of personal care assistant services developed by the qualified professional or the recipient's physician with the recipient or responsible party to be used by the personal care assistant with a copy provided to the recipient or responsible party.

(d) "Complex and regular private duty nursing care" means:

(1) complex care is private duty nursing provided to recipients who are ventilator dependent or for whom a physician has certified that were it not for private duty nursing the recipient would meet the criteria for inpatient hospital intensive care unit (ICU) level of care; and

(2) regular care is private duty nursing provided to all other recipients.

(e) "Health-related functions" means functions that can be delegated or assigned by a licensed health care professional under state law to be performed by a personal care attendant.

(f) "Home care services" means a health service, determined by the commissioner as medically necessary, that is ordered by a physician and documented in a service plan that is reviewed by the physician at least once every 60 days for the provision of home health services, or private duty nursing, or at least once every 365 days for personal care. Home care services are provided to the recipient at the recipient's residence that is a place other than a hospital or long-term care facility or as specified in section 256B.0625.

(g) "Instrumental activities of daily living" includes meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communication by telephone and other media, and getting around and participating in the community.

(h) "Medically necessary" has the meaning given in Minnesota Rules, parts 9505.0170 to 9505.0475.

(i) "Personal care assistant" means a person who:

(1) is at least 18 years old, except for persons 16 to 18 years of age who participated in a related school-based job training program or have completed a certified home health aide competency evaluation;

(2) is able to effectively communicate with the recipient and personal care provider organization;

(3) effective July 1, 1996, has completed one of the training requirements as specified in Minnesota Rules, part 9505.0335, subpart 3, items A to D;

(4) has the ability to, and provides covered personal care assistant services according to the recipient's care plan, responds appropriately to recipient needs, and reports changes in the recipient's condition to the supervising qualified professional or physician;

(5) is not a consumer of personal care assistant services; and

(6) is subject to criminal background checks and procedures specified in section 245A.04.

(j) "Personal care provider organization" means an organization enrolled to provide personal care assistant services under the medical assistance program that complies with the following: (1) owners who have a five percent interest or more, and managerial officials are subject to a background study as provided in section 245A.04. This applies to currently enrolled personal care provider organizations and those agencies seeking enrollment as a personal care provider organization. An organization will be barred from enrollment if an owner or managerial official of the organization has been convicted of a crime specified in section 245A.04, or a comparable crime in another jurisdiction, unless the owner or managerial official meets the reconsideration criteria specified in section 245A.04; (2) the organization must maintain a surety bond

and liability insurance throughout the duration of enrollment and provides proof thereof. The insurer must notify the department of human services of the cancellation or lapse of policy; and (3) the organization must maintain documentation of services as specified in Minnesota Rules, part 9505.2175, subpart 7, as well as evidence of compliance with personal care assistant training requirements.

(k) "Responsible party" means an individual residing with a recipient of personal care assistant services who is capable of providing the supportive care necessary to assist the recipient to live in the community, is at least 18 years old, and is not a personal care assistant. Responsible parties who are parents of minors or guardians of minors or incapacitated persons may delegate the responsibility to another adult during a temporary absence of at least 24 hours but not more than six months. The person delegated as a responsible party must be able to meet the definition of responsible party, except that the delegated responsible party is required to reside with the recipient only while serving as the responsible party. Foster care license holders may be designated the responsible party for residents of the foster care home if case management is provided as required in section 256B.0625, subdivision 19a. For persons who, as of April 1, 1992, are sharing personal care assistant services in order to obtain the availability of 24-hour coverage, an employee of the personal care provider organization may be designated as the responsible party if case management is provided as required in section 256B.0625, subdivision 19a.

(l) "Service plan" means a written description of the services needed based on the assessment developed by the nurse who conducts the assessment together with the recipient or responsible party. The service plan shall include a description of the covered home care services, frequency and duration of services, and expected outcomes and goals. The recipient and the provider chosen by the recipient or responsible party must be given a copy of the completed service plan within 30 calendar days of the request for home care services by the recipient or responsible party.

(m) "Skilled nurse visits" are provided in a recipient's residence under a plan of care or service plan that specifies a level of care which the nurse is qualified to provide. These services are:

(1) nursing services according to the written plan of care or service plan and accepted standards of medical and nursing practice in accordance with chapter 148;

(2) services which due to the recipient's medical condition may only be safely and effectively provided by a registered nurse or a licensed practical nurse;

(3) assessments performed only by a registered nurse; and

(4) teaching and training the recipient, the recipient's family, or other caregivers requiring the skills of a registered nurse or licensed practical nurse.

(n) "Telehomecare" means the use of telecommunications technology by a home health care professional to deliver home health care services, within the professional's scope of practice, to a patient located at a site other than the site where the practitioner is located.

Subd. 2. **Services covered.** Home care services covered under this section include:

(1) nursing services under section 256B.0625, subdivision 6a;

(2) private duty nursing services under section 256B.0625, subdivision 7;

(3) home health services under section 256B.0625, subdivision 6a;

(4) personal care assistant services under section 256B.0625, subdivision 19a;

(5) supervision of personal care assistant services provided by a qualified professional under section 256B.0625, subdivision 19a;

(6) qualified professional of personal care assistant services under the fiscal intermediary option as specified in subdivision 10;

(7) face-to-face assessments by county public health nurses for services under section 256B.0625, subdivision 19a; and

(8) service updates and review of temporary increases for personal care assistant services by the county public health nurse for services under section 256B.0625, subdivision 19a.

Subd. 4. **Personal care assistant services.** (a) The personal care assistant services that are eligible for payment are services and supports furnished to an individual, as needed, to assist in accomplishing activities of daily living; instrumental activities of daily living; health-related functions through hands-on assistance, supervision, and cuing; and redirection and intervention for behavior including observation and monitoring.

(b) Payment for services will be made within the limits approved using the prior authorized process established in subdivision 5.

(c) The amount and type of services authorized shall be based on an assessment of the recipient's needs in these areas:

(1) bowel and bladder care;

(2) skin care to maintain the health of the skin;

(3) repetitive maintenance range of motion, muscle strengthening exercises, and other tasks specific to maintaining a recipient's optimal level of function;

(4) respiratory assistance;

(5) transfers and ambulation;

(6) bathing, grooming, and hairwashing necessary for personal hygiene;

(7) turning and positioning;

(8) assistance with furnishing medication that is self-administered;

(9) application and maintenance of prosthetics and orthotics;

(10) cleaning medical equipment;

(11) dressing or undressing;

(12) assistance with eating and meal preparation and necessary grocery shopping;

(13) accompanying a recipient to obtain medical diagnosis or treatment;

(14) assisting, monitoring, or prompting the recipient to complete the services in clauses (1) to (13);

(15) redirection, monitoring, and observation that are medically necessary and an integral part of completing the personal care assistant services described in clauses (1) to (14);

(16) redirection and intervention for behavior, including observation and monitoring;

(17) interventions for seizure disorders, including monitoring and observation if the recipient has had a seizure that requires intervention within the past three months;

(18) tracheostomy suctioning using a clean procedure if the procedure is properly delegated by a registered nurse. Before this procedure can be delegated to a personal care assistant, a registered nurse must determine that the tracheostomy suctioning can be accomplished utilizing a clean rather than a sterile procedure and must ensure that the personal care assistant has been taught the proper procedure; and

(19) incidental household services that are an integral part of a personal care service described in clauses (1) to (18).

For purposes of this subdivision, monitoring and observation means watching for outward visible signs that are likely to occur and for which there is a covered personal care service or an appropriate personal care intervention. For purposes of this subdivision, a clean procedure refers to a procedure that reduces the numbers of microorganisms or prevents or reduces the transmission of microorganisms from one person or place to another. A clean procedure may be used beginning 14 days after insertion.

(d) The personal care assistant services that are not eligible for payment are the following:

(1) services not ordered by the physician;

(2) assessments by personal care assistant provider organizations or by independently enrolled registered nurses;

(3) services that are not in the service plan;

(4) services provided by the recipient's spouse, legal guardian for an adult or child recipient, or parent of a recipient under age 18;

(5) services provided by a foster care provider of a recipient who cannot direct the recipient's own care, unless monitored by a county or state case manager under section 256B.0625, subdivision 19a;

(6) services provided by the residential or program license holder in a residence for more than four persons;

(7) services that are the responsibility of a residential or program license holder under the terms of a service agreement and administrative rules;

(8) sterile procedures;

(9) injections of fluids into veins, muscles, or skin;

(10) services provided by parents of adult recipients, adult children, or siblings of the recipient, unless these relatives meet one of the following hardship criteria and the commissioner waives this requirement:

(i) the relative resigns from a part-time or full-time job to provide personal care for the recipient;

(ii) the relative goes from a full-time to a part-time job with less compensation to provide personal care for the recipient;

(iii) the relative takes a leave of absence without pay to provide personal care for the recipient;

(iv) the relative incurs substantial expenses by providing personal care for the recipient; or

(v) because of labor conditions, special language needs, or intermittent hours of care needed, the relative is needed in order to provide an adequate number of qualified personal care assistants to meet the medical needs of the recipient;

(11) homemaker services that are not an integral part of a personal care assistant services;

(12) home maintenance, or chore services;

(13) services not specified under paragraph (a); and

(14) services not authorized by the commissioner or the commissioner's designee.

(e) The recipient or responsible party may choose to supervise the personal care assistant or to have a qualified professional, as defined in section 256B.0625, subdivision 19c, provide the supervision. As required under section 256B.0625, subdivision 19c, the county public health nurse, as a part of the assessment, will assist the recipient or responsible party to identify the most appropriate person to provide supervision of the personal care assistant. Health-related delegated tasks performed by the personal care assistant will be under the supervision of a qualified professional or the direction of the recipient's physician. If the recipient has a qualified professional, Minnesota Rules, part 9505.0335, subpart 4, applies.

Subd. 5. **Limitation on payments.** Medical assistance payments for home care services shall be limited according to this subdivision.

(a) **Limits on services without prior authorization.** A recipient may receive the following home care services during a calendar year:

(1) up to two face-to-face assessments to determine a recipient's need for personal care assistant services;

(2) one service update done to determine a recipient's need for personal care assistant services; and

(3) up to nine skilled nurse visits.

(b) **Prior authorization; exceptions.** All home care services above the limits in paragraph (a) must receive the commissioner's prior authorization, except when:

(1) the home care services were required to treat an emergency medical condition that if not immediately treated could cause a recipient serious physical or mental disability, continuation of severe pain, or death. The provider must request retroactive authorization no later than five working days after giving the initial service. The provider must be able to substantiate the emergency by documentation such as reports, notes, and admission or discharge histories;

(2) the home care services were provided on or after the date on which the recipient's eligibility began, but before the date on which the recipient was notified that the case was opened. Authorization will be considered if the request is submitted by the provider within 20 working days of the date the recipient was notified that the case was opened;

(3) a third-party payor for home care services has denied or adjusted a payment. Authorization requests must be submitted by the provider within 20 working days of the notice of denial or adjustment. A copy of the notice must be included with the request;

(4) the commissioner has determined that a county or state human services agency has made an error; or

(5) the professional nurse determines an immediate need for up to 40 skilled nursing or home health aide visits per calendar year and submits a request for authorization within 20 working days of the initial service date, and medical assistance is determined to be the appropriate payer.

(c) **Retroactive authorization.** A request for retroactive authorization will be evaluated according to the same criteria applied to prior authorization requests.

(d) **Assessment and service plan.** Assessments under section 256B.0627, subdivision 1, paragraph (a), shall be conducted initially, and at least annually thereafter, in person with the recipient and result in a completed service plan using forms specified by the commissioner. Within 30 days of recipient or responsible party request for home care services, the assessment, the service plan, and other information necessary to determine medical necessity such as diagnostic or testing information, social or medical histories, and hospital or facility discharge summaries shall be submitted to the commissioner. Notwithstanding the provisions of section 256B.0627, subdivision 12, the commissioner shall maximize federal financial participation to pay for public health nurse assessments for personal care services. For personal care assistant services:

(1) The amount and type of service authorized based upon the assessment and service plan will follow the recipient if the recipient chooses to change providers.

(2) If the recipient's medical need changes, the recipient's provider may assess the need for a change in service authorization and request the change from the county public health nurse. Within 30 days of the request, the public health nurse will determine whether to request the change in services based upon the provider assessment, or conduct a home visit to assess the need and determine whether the change is appropriate.

(3) To continue to receive personal care assistant services after the first year, the recipient or the responsible party, in conjunction with the public health nurse, may complete a service update on forms developed by the commissioner according to criteria and procedures in subdivision 1.

(e) **Prior authorization.** The commissioner, or the commissioner's designee, shall review the assessment, service update, request for temporary services, service plan, and any additional information that is submitted. The commissioner shall, within 30 days after receiving a complete request, assessment, and service plan, authorize home care services as follows:

(1) **Home health services.** All home health services provided by a home health aide must be prior authorized by the commissioner or the commissioner's designee. Prior authorization must be based on medical necessity and cost-effectiveness when com-

pared with other care options. When home health services are used in combination with personal care and private duty nursing, the cost of all home care services shall be considered for cost-effectiveness. The commissioner shall limit home health aide visits to no more than one visit each per day. The commissioner, or the commissioner's designee, may authorize up to two skilled nurse visits per day.

(2) **Personal care assistant services.** (i) All personal care assistant services and supervision by a qualified professional, if requested by the recipient, must be prior authorized by the commissioner or the commissioner's designee except for the assessments established in paragraph (a). The amount of personal care assistant services authorized must be based on the recipient's home care rating. A child may not be found to be dependent in an activity of daily living if because of the child's age an adult would either perform the activity for the child or assist the child with the activity and the amount of assistance needed is similar to the assistance appropriate for a typical child of the same age. Based on medical necessity, the commissioner may authorize:

(A) up to two times the average number of direct care hours provided in nursing facilities for the recipient's comparable case mix level; or

(B) up to three times the average number of direct care hours provided in nursing facilities for recipients who have complex medical needs or are dependent in at least seven activities of daily living and need physical assistance with eating or have a neurological diagnosis; or

(C) up to 60 percent of the average reimbursement rate, as of July 1, 1991, for care provided in a regional treatment center for recipients who have Level I behavior, plus any inflation adjustment as provided by the legislature for personal care service; or

(D) up to the amount the commissioner would pay, as of July 1, 1991, plus any inflation adjustment provided for home care services, for care provided in a regional treatment center for recipients referred to the commissioner by a regional treatment center preadmission evaluation team. For purposes of this clause, home care services means all services provided in the home or community that would be included in the payment to a regional treatment center; or

(E) up to the amount medical assistance would reimburse for facility care for recipients referred to the commissioner by a preadmission screening team established under section 256B.0911 or 256B.092; and

(F) a reasonable amount of time for the provision of supervision by a qualified professional of personal care assistant services, if a qualified professional is requested by the recipient or responsible party.

(ii) The number of direct care hours shall be determined according to the annual cost report submitted to the department by nursing facilities. The average number of direct care hours, as established by May 1, 1992, shall be calculated and incorporated into the home care limits on July 1, 1992. These limits shall be calculated to the nearest quarter hour.

(iii) The home care rating shall be determined by the commissioner or the commissioner's designee based on information submitted to the commissioner by the county public health nurse on forms specified by the commissioner. The home care rating shall be a combination of current assessment tools developed under sections 256B.0911 and 256B.501 with an addition for seizure activity that will assess the frequency and severity of seizure activity and with adjustments, additions, and clarifications that are necessary to reflect the needs and conditions of recipients who need home care including children and adults under 65 years of age. The commissioner shall establish these forms and protocols under this section and shall use an advisory group, including representatives of recipients, providers, and counties, for consultation in establishing and revising the forms and protocols.

(iv) A recipient shall qualify as having complex medical needs if the care required is difficult to perform and because of recipient's medical condition requires more time than community-based standards allow or requires more skill than would ordinarily be required and the recipient needs or has one or more of the following:

(A) daily tube feedings;

(B) daily parenteral therapy;

(C) wound or decubiti care;

(D) postural drainage, percussion, nebulizer treatments, suctioning, tracheotomy care, oxygen, mechanical ventilation;

(E) catheterization;

(F) ostomy care;

(G) quadriplegia; or

(H) other comparable medical conditions or treatments the commissioner determines would otherwise require institutional care.

(v) A recipient shall qualify as having Level I behavior if there is reasonable supporting evidence that the recipient exhibits, or that without supervision, observation, or redirection would exhibit, one or more of the following behaviors that cause, or have the potential to cause:

(A) injury to the recipient's own body;

(B) physical injury to other people; or

(C) destruction of property.

(vi) Time authorized for personal care relating to Level I behavior in subclause (v), items (A) to (C), shall be based on the predictability, frequency, and amount of intervention required.

(vii) A recipient shall qualify as having Level II behavior if the recipient exhibits on a daily basis one or more of the following behaviors that interfere with the completion of personal care assistant services under subdivision 4, paragraph (a):

(A) unusual or repetitive habits;

(B) withdrawn behavior; or

(C) offensive behavior.

(viii) A recipient with a home care rating of Level II behavior in subclause (vii), items (A) to (C), shall be rated as comparable to a recipient with complex medical needs under subclause (iv). If a recipient has both complex medical needs and Level II behavior, the home care rating shall be the next complex category up to the maximum rating under subclause (i), item (B).

(3) **Private duty nursing services.** All private duty nursing services shall be prior authorized by the commissioner or the commissioner's designee. Prior authorization for private duty nursing services shall be based on medical necessity and cost-effectiveness when compared with alternative care options. The commissioner may authorize medically necessary private duty nursing services in quarter-hour units when:

(i) the recipient requires more individual and continuous care than can be provided during a nurse visit; or

(ii) the cares are outside of the scope of services that can be provided by a home health aide or personal care assistant.

The commissioner may authorize:

(A) up to two times the average amount of direct care hours provided in nursing facilities statewide for case mix classification "K" as established by the annual cost report submitted to the department by nursing facilities in May 1992;

(B) private duty nursing in combination with other home care services up to the total cost allowed under clause (2);

(C) up to 16 hours per day if the recipient requires more nursing than the maximum number of direct care hours as established in item (A) and the recipient meets the hospital admission criteria established under Minnesota Rules, parts 9505.0501 to 9505.0540.

The commissioner may authorize up to 16 hours per day of medically necessary private duty nursing services or up to 24 hours per day of medically necessary private duty nursing services until such time as the commissioner is able to make a determination of eligibility for recipients who are cooperatively applying for home care services

under the community alternative care program developed under section 256B.49, or until it is determined by the appropriate regulatory agency that a health benefit plan is or is not required to pay for appropriate medically necessary health care services. Recipients or their representatives must cooperatively assist the commissioner in obtaining this determination. Recipients who are eligible for the community alternative care program may not receive more hours of nursing under this section than would otherwise be authorized under section 256B.49.

(4) **Ventilator-dependent recipients.** If the recipient is ventilator-dependent, the monthly medical assistance authorization for home care services shall not exceed what the commissioner would pay for care at the highest cost hospital designated as a long-term hospital under the Medicare program. For purposes of this clause, home care services means all services provided in the home that would be included in the payment for care at the long-term hospital. "Ventilator-dependent" means an individual who receives mechanical ventilation for life support at least six hours per day and is expected to be or has been dependent for at least 30 consecutive days.

(f) **Prior authorization; time limits.** The commissioner or the commissioner's designee shall determine the time period for which a prior authorization shall be effective. If the recipient continues to require home care services beyond the duration of the prior authorization, the home care provider must request a new prior authorization. Under no circumstances, other than the exceptions in paragraph (b), shall a prior authorization be valid prior to the date the commissioner receives the request or for more than 12 months. A recipient who appeals a reduction in previously authorized home care services may continue previously authorized services, other than temporary services under paragraph (h), pending an appeal under section 256.045. The commissioner must provide a detailed explanation of why the authorized services are reduced in amount from those requested by the home care provider.

(g) **Approval of home care services.** The commissioner or the commissioner's designee shall determine the medical necessity of home care services, the level of caregiver according to subdivision 2, and the institutional comparison according to this subdivision, the cost-effectiveness of services, and the amount, scope, and duration of home care services reimbursable by medical assistance, based on the assessment, primary payer coverage determination information as required, the service plan, the recipient's age, the cost of services, the recipient's medical condition, and diagnosis or disability. The commissioner may publish additional criteria for determining medical necessity according to section 256B.04.

(h) **Prior authorization requests; temporary services.** The agency nurse, the independently enrolled private duty nurse, or county public health nurse may request a temporary authorization for home care services by telephone. The commissioner may approve a temporary level of home care services based on the assessment, and service or care plan information, and primary payer coverage determination information as required. Authorization for a temporary level of home care services including nurse supervision is limited to the time specified by the commissioner, but shall not exceed 45 days, unless extended because the county public health nurse has not completed the required assessment and service plan, or the commissioner's determination has not been made. The level of services authorized under this provision shall have no bearing on a future prior authorization.

(i) **Prior authorization required in foster care setting.** Home care services provided in an adult or child foster care setting must receive prior authorization by the department according to the limits established in paragraph (a).

The commissioner may not authorize:

(1) home care services that are the responsibility of the foster care provider under the terms of the foster care placement agreement and administrative rules;

(2) personal care assistant services when the foster care license holder is also the personal care provider or personal care assistant unless the recipient can direct the recipient's own care, or case management is provided as required in section 256B.0625, subdivision 19a;

(3) personal care assistant services when the responsible party is an employee of, or under contract with, or has any direct or indirect financial relationship with the personal care provider or personal care assistant, unless case management is provided as required in section 256B.0625, subdivision 19a; or

(4) personal care assistant and private duty nursing services when the number of foster care residents is greater than four unless the county responsible for the recipient's foster placement made the placement prior to April 1, 1992, requests that personal care assistant and private duty nursing services be provided, and case management is provided as required in section 256B.0625, subdivision 19a.

[For text of subd 6, see M.S.2000]

Subd. 7. **Noncovered home care services.** The following home care services are not eligible for payment under medical assistance:

(1) skilled nurse visits for the sole purpose of supervision of the home health aide;

(2) a skilled nursing visit:

(i) only for the purpose of monitoring medication compliance with an established medication program for a recipient; or

(ii) to administer or assist with medication administration, including injections, prefilling syringes for injections, or oral medication set-up of an adult recipient, when as determined and documented by the registered nurse, the need can be met by an available pharmacy or the recipient is physically and mentally able to self-administer or prefill a medication;

(3) home care services to a recipient who is eligible for covered services under the Medicare program or any other insurance held by the recipient;

(4) services to other members of the recipient's household;

(5) a visit made by a skilled nurse solely to train other home health agency workers;

(6) any home care service included in the daily rate of the community-based residential facility where the recipient is residing;

(7) nursing and rehabilitation therapy services that are reasonably accessible to a recipient outside the recipient's place of residence, excluding the assessment, counseling and education, and personal assistant care;

(8) any home health agency service, excluding personal care assistant services and private duty nursing services, which are performed in a place other than the recipient's residence; and

(9) Medicare evaluation or administrative nursing visits on dual-eligible recipients that do not qualify for Medicare visit billing.

Subd. 8. **Shared personal care assistant services.** (a) Medical assistance payments for shared personal care assistance services shall be limited according to this subdivision.

(b) Recipients of personal care assistant services may share staff and the commissioner shall provide a rate system for shared personal care assistant services. For two persons sharing services, the rate paid to a provider shall not exceed 1-1/2 times the rate paid for serving a single individual, and for three persons sharing services, the rate paid to a provider shall not exceed twice the rate paid for serving a single individual. These rates apply only to situations in which all recipients were present and received shared services on the date for which the service is billed. No more than three persons may receive shared services from a personal care assistant in a single setting.

(c) Shared service is the provision of personal care assistant services by a personal care assistant to two or three recipients at the same time and in the same setting. For the purposes of this subdivision, "setting" means:

(1) the home or foster care home of one of the individual recipients; or

(2) a child care program in which all recipients served by one personal care assistant are participating, which is licensed under chapter 245A or operated by a local school district or private school; or

(3) outside the home or foster care home of one of the recipients when normal life activities take the recipients outside the home.

The provisions of this subdivision do not apply when a personal care assistant is caring for multiple recipients in more than one setting.

(d) The recipient or the recipient's responsible party, in conjunction with the county public health nurse, shall determine:

(1) whether shared personal care assistant services is an appropriate option based on the individual needs and preferences of the recipient; and

(2) the amount of shared services allocated as part of the overall authorization of personal care assistant services.

The recipient or the responsible party, in conjunction with the supervising qualified professional, if a qualified professional is requested by any one of the recipients or responsible parties, shall arrange the setting and grouping of shared services based on the individual needs and preferences of the recipients. Decisions on the selection of recipients to share services must be based on the ages of the recipients, compatibility, and coordination of their care needs.

(e) The following items must be considered by the recipient or the responsible party and the supervising qualified professional, if a qualified professional has been requested by any one of the recipients or responsible parties, and documented in the recipient's health service record:

(1) the additional qualifications needed by the personal care assistant to provide care to several recipients in the same setting;

(2) the additional training and supervision needed by the personal care assistant to ensure that the needs of the recipient are met appropriately and safely. The provider must provide on-site supervision by a qualified professional within the first 14 days of shared services, and monthly thereafter, if supervision by a qualified provider has been requested by any one of the recipients or responsible parties;

(3) the setting in which the shared services will be provided;

(4) the ongoing monitoring and evaluation of the effectiveness and appropriateness of the service and process used to make changes in service or setting; and

(5) a contingency plan which accounts for absence of the recipient in a shared services setting due to illness or other circumstances and staffing contingencies.

(f) The provider must offer the recipient or the responsible party the option of shared or one-on-one personal care assistant services. The recipient or the responsible party can withdraw from participating in a shared services arrangement at any time.

(g) In addition to documentation requirements under Minnesota Rules, part 9505.2175, a personal care provider must meet documentation requirements for shared personal care assistant services and must document the following in the health service record for each individual recipient sharing services:

(1) permission by the recipient or the recipient's responsible party, if any, for the maximum number of shared services hours per week chosen by the recipient;

(2) permission by the recipient or the recipient's responsible party, if any, for personal care assistant services provided outside the recipient's residence;

(3) permission by the recipient or the recipient's responsible party, if any, for others to receive shared services in the recipient's residence;

(4) revocation by the recipient or the recipient's responsible party, if any, of the shared service authorization, or the shared service to be provided to others in the recipient's residence, or the shared service to be provided outside the recipient's residence;

(5) supervision of the shared personal care assistant services by the qualified professional, if a qualified professional is requested by one of the recipients or

responsible parties, including the date, time of day, number of hours spent supervising the provision of shared services, whether the supervision was face-to-face or another method of supervision, changes in the recipient's condition, shared services scheduling issues and recommendations;

(6) documentation by the qualified professional, if a qualified professional is requested by one of the recipients or responsible parties, of telephone calls or other discussions with the personal care assistant regarding services being provided to the recipient who has requested the supervision; and

(7) daily documentation of the shared services provided by each identified personal care assistant including:

(i) the names of each recipient receiving shared services together;

(ii) the setting for the shared services, including the starting and ending times that the recipient received shared services; and

(iii) notes by the personal care assistant regarding changes in the recipient's condition, problems that may arise from the sharing of services, scheduling issues, care issues, and other notes as required by the qualified professional, if a qualified professional is requested by one of the recipients or responsible parties.

(h) Unless otherwise provided in this subdivision, all other statutory and regulatory provisions relating to personal care assistant services apply to shared services.

(i) In the event that supervision by a qualified professional has been requested by one or more recipients, but not by all of the recipients, the supervision duties of the qualified professional shall be limited to only those recipients who have requested the supervision.

Nothing in this subdivision shall be construed to reduce the total number of hours authorized for an individual recipient.

[For text of subd 9, see M.S.2000]

Subd. 10. **Fiscal intermediary option available for personal care assistant services.** (a) The commissioner may allow a recipient of personal care assistant services to use a fiscal intermediary to assist the recipient in paying and accounting for medically necessary covered personal care assistant services authorized in subdivision 4 and within the payment parameters of subdivision 5. Unless otherwise provided in this subdivision, all other statutory and regulatory provisions relating to personal care assistant services apply to a recipient using the fiscal intermediary option.

(b) The recipient or responsible party shall:

(1) recruit, hire, and terminate a qualified professional, if a qualified professional is requested by the recipient or responsible party;

(2) verify and document the credentials of the qualified professional, if a qualified professional is requested by the recipient or responsible party;

(3) develop a service plan based on physician orders and public health nurse assessment with the assistance of a qualified professional, if a qualified professional is requested by the recipient or responsible party, that addresses the health and safety of the recipient;

(4) recruit, hire, and terminate the personal care assistant;

(5) orient and train the personal care assistant with assistance as needed from the qualified professional;

(6) supervise and evaluate the personal care assistant with assistance as needed from the recipient's physician or the qualified professional;

(7) monitor and verify in writing and report to the fiscal intermediary the number of hours worked by the personal care assistant and the qualified professional; and

(8) enter into a written agreement, as specified in paragraph (f).

(c) The duties of the fiscal intermediary shall be to:

(1) bill the medical assistance program for personal care assistant and qualified professional services;

(2) request and secure background checks on personal care assistants and qualified professionals according to section 245A.04;

(3) pay the personal care assistant and qualified professional based on actual hours of services provided;

(4) withhold and pay all applicable federal and state taxes;

(5) verify and keep records of hours worked by the personal care assistant and qualified professional;

(6) make the arrangements and pay unemployment insurance, taxes, workers' compensation, liability insurance, and other benefits, if any;

(7) enroll in the medical assistance program as a fiscal intermediary; and

(8) enter into a written agreement as specified in paragraph (f) before services are provided.

(d) The fiscal intermediary:

(1) may not be related to the recipient, qualified professional, or the personal care assistant;

(2) must ensure arm's length transactions with the recipient and personal care assistant; and

(3) shall be considered a joint employer of the personal care assistant and qualified professional to the extent specified in this section.

The fiscal intermediary or owners of the entity that provides fiscal intermediary services under this subdivision must pass a criminal background check as required in section 256B.0627, subdivision 1, paragraph (c).

(e) If the recipient or responsible party requests a qualified professional, the qualified professional providing assistance to the recipient shall meet the qualifications specified in section 256B.0625, subdivision 19c. The qualified professional shall assist the recipient in developing and revising a plan to meet the recipient's needs, as assessed by the public health nurse. In performing this function, the qualified professional must visit the recipient in the recipient's home at least once annually. The qualified professional must report any suspected abuse, neglect, or financial exploitation of the recipient to the appropriate authorities.

(f) The fiscal intermediary, recipient or responsible party, personal care assistant, and qualified professional shall enter into a written agreement before services are started. The agreement shall include:

(1) the duties of the recipient, qualified professional, personal care assistant, and fiscal agent based on paragraphs (a) to (e);

(2) the salary and benefits for the personal care assistant and the qualified professional;

(3) the administrative fee of the fiscal intermediary and services paid for with that fee, including background check fees;

(4) procedures to respond to billing or payment complaints; and

(5) procedures for hiring and terminating the personal care assistant and the qualified professional.

(g) The rates paid for personal care assistant services, qualified professional services, and fiscal intermediary services under this subdivision shall be the same rates paid for personal care assistant services and qualified professional services under subdivision 2 respectively. Except for the administrative fee of the fiscal intermediary specified in paragraph (f), the remainder of the rates paid to the fiscal intermediary must be used to pay for the salary and benefits for the personal care assistant or the qualified professional.

(h) As part of the assessment defined in subdivision 1, the following conditions must be met to use or continue use of a fiscal intermediary:

(1) the recipient must be able to direct the recipient's own care, or the responsible party for the recipient must be readily available to direct the care of the personal care assistant;

(2) the recipient or responsible party must be knowledgeable of the health care needs of the recipient and be able to effectively communicate those needs;

(3) a face-to-face assessment must be conducted by the local county public health nurse at least annually, or when there is a significant change in the recipient's condition or change in the need for personal care assistant services;

(4) the recipient cannot select the shared services option as specified in subdivision 8; and

(5) parties must be in compliance with the written agreement specified in paragraph (f).

(i) The commissioner shall deny, revoke, or suspend the authorization to use the fiscal intermediary option if:

(1) it has been determined by the qualified professional or local county public health nurse that the use of this option jeopardizes the recipient's health and safety;

(2) the parties have failed to comply with the written agreement specified in paragraph (f); or

(3) the use of the option has led to abusive or fraudulent billing for personal care assistant services.

The recipient or responsible party may appeal the commissioner's action according to section 256.045. The denial, revocation, or suspension to use the fiscal intermediary option shall not affect the recipient's authorized level of personal care assistant services as determined in subdivision 5.

Subd. 11. **Shared private duty nursing care option.** (a) Medical assistance payments for shared private duty nursing services by a private duty nurse shall be limited according to this subdivision. For the purposes of this section, "private duty nursing agency" means an agency licensed under chapter 144A to provide private duty nursing services.

(b) Recipients of private duty nursing services may share nursing staff and the commissioner shall provide a rate methodology for shared private duty nursing. For two persons sharing nursing care, the rate paid to a provider shall not exceed 1.5 times the regular private duty nursing rates paid for serving a single individual by a registered nurse or licensed practical nurse. These rates apply only to situations in which both recipients are present and receive shared private duty nursing care on the date for which the service is billed. No more than two persons may receive shared private duty nursing services from a private duty nurse in a single setting.

(c) Shared private duty nursing care is the provision of nursing services by a private duty nurse to two recipients at the same time and in the same setting. For the purposes of this subdivision, "setting" means:

(1) the home or foster care home of one of the individual recipients; or

(2) a child care program licensed under chapter 245A or operated by a local school district or private school; or

(3) an adult day care service licensed under chapter 245A; or

(4) outside the home or foster care home of one of the recipients when normal life activities take the recipients outside the home.

This subdivision does not apply when a private duty nurse is caring for multiple recipients in more than one setting.

(d) The recipient or the recipient's legal representative, and the recipient's physician, in conjunction with the home health care agency, shall determine:

(1) whether shared private duty nursing care is an appropriate option based on the individual needs and preferences of the recipient; and

(2) the amount of shared private duty nursing services authorized as part of the overall authorization of nursing services.

(e) The recipient or the recipient's legal representative, in conjunction with the private duty nursing agency, shall approve the setting, grouping, and arrangement of shared private duty nursing care based on the individual needs and preferences of the

recipients. Decisions on the selection of recipients to share services must be based on the ages of the recipients, compatibility, and coordination of their care needs.

(f) The following items must be considered by the recipient or the recipient's legal representative and the private duty nursing agency, and documented in the recipient's health service record:

(1) the additional training needed by the private duty nurse to provide care to two recipients in the same setting and to ensure that the needs of the recipients are met appropriately and safely;

(2) the setting in which the shared private duty nursing care will be provided;

(3) the ongoing monitoring and evaluation of the effectiveness and appropriateness of the service and process used to make changes in service or setting;

(4) a contingency plan which accounts for absence of the recipient in a shared private duty nursing setting due to illness or other circumstances;

(5) staffing backup contingencies in the event of employee illness or absence; and

(6) arrangements for additional assistance to respond to urgent or emergency care needs of the recipients.

(g) The provider must offer the recipient or responsible party the option of shared or one-on-one private duty nursing services. The recipient or responsible party can withdraw from participating in a shared service arrangement at any time.

(h) The private duty nursing agency must document the following in the health service record for each individual recipient sharing private duty nursing care:

(1) permission by the recipient or the recipient's legal representative for the maximum number of shared nursing care hours per week chosen by the recipient;

(2) permission by the recipient or the recipient's legal representative for shared private duty nursing services provided outside the recipient's residence;

(3) permission by the recipient or the recipient's legal representative for others to receive shared private duty nursing services in the recipient's residence;

(4) revocation by the recipient or the recipient's legal representative of the shared private duty nursing care authorization, or the shared care to be provided to others in the recipient's residence, or the shared private duty nursing services to be provided outside the recipient's residence; and

(5) daily documentation of the shared private duty nursing services provided by each identified private duty nurse, including:

(i) the names of each recipient receiving shared private duty nursing services together;

(ii) the setting for the shared services, including the starting and ending times that the recipient received shared private duty nursing care; and

(iii) notes by the private duty nurse regarding changes in the recipient's condition, problems that may arise from the sharing of private duty nursing services, and scheduling and care issues.

(i) Unless otherwise provided in this subdivision, all other statutory and regulatory provisions relating to private duty nursing services apply to shared private duty nursing services.

Nothing in this subdivision shall be construed to reduce the total number of private duty nursing hours authorized for an individual recipient under subdivision 5.

[For text of subd 12, see M.S.2000]

Subd. 13. **Consumer-directed home care demonstration project.** (a) Upon the receipt of federal waiver authority, the commissioner shall implement a consumer-directed home care demonstration project. The consumer-directed home care demonstration project must demonstrate and evaluate the outcomes of a consumer-directed service delivery alternative to improve access, increase consumer control and accountability over available resources, and enable the use of supports that are more individualized and cost-effective for eligible medical assistance recipients receiving certain

medical assistance home care services. The consumer-directed home care demonstration project will be administered locally by county agencies, tribal governments, or administrative entities under contract with the state in regions where counties choose not to provide this service.

(b) Grant awards for persons who have been receiving medical assistance covered personal care, home health aide, or private duty nursing services for a period of 12 consecutive months or more prior to enrollment in the consumer-directed home care demonstration project will be established on a case-by-case basis using historical service expenditure data. An average monthly expenditure for each continuing enrollee will be calculated based on historical expenditures made on behalf of the enrollee for personal care, home health aide, or private duty nursing services during the 12 month period directly prior to enrollment in the project. The grant award will equal 90 percent of the average monthly expenditure.

(c) Grant awards for project enrollees who have been receiving medical assistance covered personal care, home health aide, or private duty nursing services for a period of less than 12 consecutive months prior to project enrollment will be calculated on a case-by-case basis using the service authorization in place at the time of enrollment. The total number of units of personal care, home health aide, or private duty nursing services the enrollee has been authorized to receive will be converted to the total cost of the authorized services in a given month using the statewide average service payment rates. To determine an estimated monthly expenditure, the total authorized monthly personal care, home health aide or private duty nursing service costs will be reduced by a percentage rate equivalent to the difference between the statewide average service authorization and the statewide average utilization rate for each of the services by medical assistance eligibles during the most recent fiscal year for which 12 months of data is available. The grant award will equal 90 percent of the estimated monthly expenditure.

(d) The state of Minnesota, county agencies, tribal governments, or administrative entities under contract with the state that participate in the implementation and administration of the consumer-directed home care demonstration project, shall not be liable for damages, injuries, or liabilities sustained through the purchase of support by the individual, the individual's family, legal representative, or the authorized representative under this section with funds received through the consumer-directed home care demonstration project. Liabilities include but are not limited to: workers' compensation liability, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA).

(e) With federal approval, the commissioner may adjust methodologies in paragraphs (b) and (c) to simplify program administration, improve consistency between state and federal programs, and maximize federal financial participation.

Subd. 14. **Telehomecare; skilled nurse visits.** Medical assistance covers skilled nurse visits according to section 256B.0625, subdivision 6a, provided via telehomecare, for services which do not require hands-on care between the home care nurse and recipient. The provision of telehomecare must be made via live, two-way interactive audiovisual technology and may be augmented by utilizing store-and-forward technologies. Store-and-forward technology includes telehomecare services that do not occur in real time via synchronous transmissions, and that do not require a face-to-face encounter with the recipient for all or any part of any such telehomecare visit. Individually identifiable patient data obtained through real-time or store-and-forward technology must be maintained as health records according to section 144.335. If the video is used for research, training, or other purposes unrelated to the care of the patient, the identity of the patient must be concealed. A communication between the home care nurse and recipient that consists solely of a telephone conversation, facsimile, electronic mail, or a consultation between two health care practitioners, is not to be considered a telehomecare visit. Multiple daily skilled nurse visits provided via telehomecare are allowed. Coverage of telehomecare is limited to two visits per day. All skilled nurse visits provided via telehomecare must be prior authorized by the

commissioner or the commissioner's designee and will be covered at the same allowable rate as skilled nurse visits provided in-person.

Subd. 15. **Therapies through home health agencies.** (a) **Physical therapy.** Medical assistance covers physical therapy and related services, including specialized maintenance therapy. Services provided by a physical therapy assistant shall be reimbursed at the same rate as services performed by a physical therapist when the services of the physical therapy assistant are provided under the direction of a physical therapist who is on the premises. Services provided by a physical therapy assistant that are provided under the direction of a physical therapist who is not on the premises shall be reimbursed at 65 percent of the physical therapist rate. Direction of the physical therapy assistant must be provided by the physical therapist as described in Minnesota Rules, part 9505.0390, subpart 1, item B. The physical therapist and physical therapist assistant may not both bill for services provided to a recipient on the same day.

(b) **Occupational therapy.** Medical assistance covers occupational therapy and related services, including specialized maintenance therapy. Services provided by an occupational therapy assistant shall be reimbursed at the same rate as services performed by an occupational therapist when the services of the occupational therapy assistant are provided under the direction of the occupational therapist who is on the premises. Services provided by an occupational therapy assistant under the direction of an occupational therapist who is not on the premises shall be reimbursed at 65 percent of the occupational therapist rate. Direction of the occupational therapy assistant must be provided by the occupational therapist as described in Minnesota Rules, part 9505.0390, subpart 1, item B. The occupational therapist and occupational therapist assistant may not both bill for services provided to a recipient on the same day.

Subd. 16. **Hardship criteria; private duty nursing.** (a) Payment is allowed for extraordinary services that require specialized nursing skills and are provided by parents of minor children, spouses, and legal guardians who are providing private duty nursing care under the following conditions:

(1) the provision of these services is not legally required of the parents, spouses, or legal guardians;

(2) the services are necessary to prevent hospitalization of the recipient; and

(3) the recipient is eligible for state plan home care or a home and community-based waiver and one of the following hardship criteria are met:

(i) the parent, spouse, or legal guardian resigns from a part-time or full-time job to provide nursing care for the recipient; or

(ii) the parent, spouse, or legal guardian goes from a full-time to a part-time job with less compensation to provide nursing care for the recipient; or

(iii) the parent, spouse, or legal guardian takes a leave of absence without pay to provide nursing care for the recipient; or

(iv) because of labor conditions, special language needs, or intermittent hours of care needed, the parent, spouse, or legal guardian is needed in order to provide adequate private duty nursing services to meet the medical needs of the recipient.

(b) Private duty nursing may be provided by a parent, spouse, or legal guardian who is a nurse licensed in Minnesota. Private duty nursing services provided by a parent, spouse, or legal guardian cannot be used in lieu of nursing services covered and available under liable third-party payors, including Medicare. The private duty nursing provided by a parent, spouse, or legal guardian must be included in the service plan. Authorized skilled nursing services provided by the parent, spouse, or legal guardian may not exceed 50 percent of the total approved nursing hours, or eight hours per day, whichever is less, up to a maximum of 40 hours per week. Nothing in this subdivision precludes the parent's, spouse's, or legal guardian's obligation of assuming the non-reimbursed family responsibilities of emergency backup caregiver and primary caregiver.

(c) A parent or a spouse may not be paid to provide private duty nursing care if the parent or spouse fails to pass a criminal background check according to section

245A.04, or if it has been determined by the home health agency, the case manager, or the physician that the private duty nursing care provided by the parent, spouse, or legal guardian is unsafe.

Subd. 17. **Quality assurance plan for personal care assistant services.** The commissioner shall establish a quality assurance plan for personal care assistant services that includes:

(1) performance-based provider agreements;

(2) meaningful consumer input, which may include consumer surveys, that measure the extent to which participants receive the services and supports described in the individual plan and participant satisfaction with such services and supports;

(3) ongoing monitoring of the health and well-being of consumers; and

(4) an ongoing public process for development, implementation, and review of the quality assurance plan.

History: *1Sp2001 c 9 art 3 s 29-41*

256B.0635 CONTINUED ELIGIBILITY IN SPECIAL CIRCUMSTANCES.

Subdivision 1. **Increased employment.** (a) Until June 30, 2002, medical assistance may be paid for persons who received MFIP-S or medical assistance for families and children in at least three of six months preceding the month in which the person became ineligible for MFIP-S or medical assistance, if the ineligibility was due to an increase in hours of employment or employment income or due to the loss of an earned income disregard. In addition, to receive continued assistance under this section, persons who received medical assistance for families and children but did not receive MFIP-S must have had income less than or equal to the assistance standard for their family size under the state's AFDC plan in effect as of July 16, 1996, increased by three percent effective July 1, 2000, at the time medical assistance eligibility began. A person who is eligible for extended medical assistance is entitled to six months of assistance without reapplication, unless the assistance unit ceases to include a dependent child. For a person under 21 years of age, medical assistance may not be discontinued within the six-month period of extended eligibility until it has been determined that the person is not otherwise eligible for medical assistance. Medical assistance may be continued for an additional six months if the person meets all requirements for the additional six months, according to title XIX of the Social Security Act, as amended by section 303 of the Family Support Act of 1988, Public Law Number 100-485.

(b) Beginning July 1, 2002, medical assistance for families and children may be paid for persons who were eligible under section 256B.055, subdivision 3a, in at least three of six months preceding the month in which the person became ineligible under that section if the ineligibility was due to an increase in hours of employment or employment income or due to the loss of an earned income disregard. A person who is eligible for extended medical assistance is entitled to six months of assistance without reapplication, unless the assistance unit ceases to include a dependent child, except medical assistance may not be discontinued for that dependent child under 21 years of age within the six-month period of extended eligibility until it has been determined that the person is not otherwise eligible for medical assistance. Medical assistance may be continued for an additional six months if the person meets all requirements for the additional six months, according to title XIX of the Social Security Act, as amended by section 303 of the Family Support Act of 1988, Public Law Number 100-485.

Subd. 2. **Increased child or spousal support.** (a) Until June 30, 2002, medical assistance may be paid for persons who received MFIP-S or medical assistance for families and children in at least three of the six months preceding the month in which the person became ineligible for MFIP-S or medical assistance, if the ineligibility was the result of the collection of child or spousal support under part D of title IV of the Social Security Act. In addition, to receive continued assistance under this section, persons who received medical assistance for families and children but did not receive MFIP-S must have had income less than or equal to the assistance standard for their

family size under the state's AFDC plan in effect as of July 16, 1996, increased by three percent effective July 1, 2000, at the time medical assistance eligibility began. A person who is eligible for extended medical assistance under this subdivision is entitled to four months of assistance without reapplication, unless the assistance unit ceases to include a dependent child, except medical assistance may not be discontinued for that dependent child under 21 years of age within the four-month period of extended eligibility until it has been determined that the person is not otherwise eligible for medical assistance.

(b) Beginning July 1, 2002, medical assistance for families and children may be paid for persons who were eligible under section 256B.055, subdivision 3a, in at least three of the six months preceding the month in which the person became ineligible under that section if the ineligibility was the result of the collection of child or spousal support under part D of title IV of the Social Security Act. A person who is eligible for extended medical assistance under this subdivision is entitled to four months of assistance without reapplication, unless the assistance unit ceases to include a dependent child, except medical assistance may not be discontinued for that dependent child under 21 years of age within the four-month period of extended eligibility until it has been determined that the person is not otherwise eligible for medical assistance.

Subd. 3. [Repealed, 1Sp2001 c 9 art 2 s 76]

History: *1Sp2001 c 9 art 2 s 40,41*

256B.0637 PRESUMPTIVE ELIGIBILITY FOR CERTAIN PERSONS NEEDING TREATMENT FOR BREAST OR CERVICAL CANCER.

Medical assistance is available during a presumptive eligibility period for persons who meet the criteria in section 256B.057, subdivision 10. For purposes of this section, the presumptive eligibility period begins on the date on which an entity designated by the commissioner determines, based on preliminary information, that the person meets the criteria in section 256B.057, subdivision 10. The presumptive eligibility period ends on the day on which a determination is made as to the person's eligibility, except that if an application is not submitted by the last day of the month following the month during which the determination based on preliminary information is made, the presumptive eligibility period ends on that last day of the month.

History: *1Sp2001 c 9 art 2 s 42*

NOTE: This section, as added by Laws 2001, First Special Session chapter 9, article 2, section 42, is effective July 1, 2002. Laws 2001, First Special Session chapter 9, article 2, section 42, the effective date.

256B.0644 PARTICIPATION REQUIRED FOR REIMBURSEMENT UNDER OTHER STATE HEALTH CARE PROGRAMS.

A vendor of medical care, as defined in section 256B.02, subdivision 7, and a health maintenance organization, as defined in chapter 62D, must participate as a provider or contractor in the medical assistance program, general assistance medical care program, and MinnesotaCare as a condition of participating as a provider in health insurance plans and programs or contractor for state employees established under section 43A.18, the public employees insurance program under section 43A.316, for health insurance plans offered to local statutory or home rule charter city, county, and school district employees, the workers' compensation system under section 176.135, and insurance plans provided through the Minnesota comprehensive health association under sections 62E.01 to 62E.19. The limitations on insurance plans offered to local government employees shall not be applicable in geographic areas where provider participation is limited by managed care contracts with the department of human services. For providers other than health maintenance organizations, participation in the medical assistance program means that (1) the provider accepts new medical assistance, general assistance medical care, and MinnesotaCare patients or (2) at least 20 percent of the provider's patients are covered by medical assistance, general assistance medical care, and MinnesotaCare as their primary source of coverage. Patients seen on a volunteer basis by the provider at a location other than the

provider's usual place of practice may be considered in meeting this participation requirement. The commissioner shall establish participation requirements for health maintenance organizations. The commissioner shall provide lists of participating medical assistance providers on a quarterly basis to the commissioner of employee relations, the commissioner of labor and industry, and the commissioner of commerce. Each of the commissioners shall develop and implement procedures to exclude as participating providers in the program or programs under their jurisdiction those providers who do not participate in the medical assistance program. The commissioner of employee relations shall implement this section through contracts with participating health and dental carriers.

History: *1Sp2001 c 9 art 2 s 43*

256B.071 MEDICARE MAXIMIZATION PROGRAM.

[For text of subd 1, see M.S.2000]

Subd. 2. **Technical assistance to providers.** (a) The commissioner shall establish a technical assistance program to require providers of services and equipment under this section to maximize collections from the federal Medicare program. The technical assistance may include the provision of materials to help providers determine those services and equipment likely to be reimbursed by Medicare.

(b) Any provider of home care services enrolled in the medical assistance program, or county public health nursing agency responsible for personal care assessments, or county case managers for alternative care or medical assistance waiver programs, is required to use the method developed and supplied by the department of human services for determining Medicare coverage for home care equipment and services provided to dual entitlees to ensure appropriate billing of Medicare.

[For text of subds 3 and 4, see M.S.2000]

Subd. 5. [Repealed, 2001 c 161 s 58; 2001 c 203 s 19]

History: *2001 c 203 s 10*

256B.0911 LONG-TERM CARE CONSULTATION SERVICES.

Subdivision 1. **Purpose and goal.** (a) The purpose of long-term care consultation services is to assist persons with long-term or chronic care needs in making long-term care decisions and selecting options that meet their needs and reflect their preferences. The availability of, and access to, information and other types of assistance is also intended to prevent or delay certified nursing facility placements and to provide transition assistance after admission. Further, the goal of these services is to contain costs associated with unnecessary certified nursing facility admissions. The commissioners of human services and health shall seek to maximize use of available federal and state funds and establish the broadest program possible within the funding available.

(b) These services must be coordinated with services provided under sections 256.975, subdivision 7, and 256.9772, and with services provided by other public and private agencies in the community to offer a variety of cost-effective alternatives to persons with disabilities and elderly persons. The county agency providing long-term care consultation services shall encourage the use of volunteers from families, religious organizations, social clubs, and similar civic and service organizations to provide community-based services.

Subd. 1a. **Definitions.** For purposes of this section, the following definitions apply:

(a) "Long-term care consultation services" means:

(1) providing information and education to the general public regarding availability of the services authorized under this section;

(2) an intake process that provides access to the services described in this section;

(3) assessment of the health, psychological, and social needs of referred individuals;

(4) assistance in identifying services needed to maintain an individual in the least restrictive environment;

(5) providing recommendations on cost-effective community services that are available to the individual;

(6) development of an individual's community support plan;

(7) providing information regarding eligibility for Minnesota health care programs;

(8) preadmission screening to determine the need for a nursing facility level of care;

(9) preliminary determination of Minnesota health care programs eligibility for individuals who need a nursing facility level of care, with appropriate referrals for final determination;

(10) providing recommendations for nursing facility placement when there are no cost-effective community services available; and

(11) assistance to transition people back to community settings after facility admission.

(b) "Minnesota health care programs" means the medical assistance program under chapter 256B, the alternative care program under section 256B.0913, and the prescription drug program under section 256.955.

Subd. 2. [Repealed, 1Sp2001 c 9 art 4 s 34]

Subd. 2a. [Repealed, 1Sp2001 c 9 art 4 s 34]

Subd. 3. **Long-term care consultation team.** (a) A long-term care consultation team shall be established by the county board of commissioners. Each local consultation team shall consist of at least one social worker and at least one public health nurse from their respective county agencies. The board may designate public health or social services as the lead agency for long-term care consultation services. If a county does not have a public health nurse available, it may request approval from the commissioner to assign a county registered nurse with at least one year experience in home care to participate on the team. Two or more counties may collaborate to establish a joint local consultation team or teams.

(b) The team is responsible for providing long-term care consultation services to all persons located in the county who request the services, regardless of eligibility for Minnesota health care programs.

Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment, services planning, or other assistance intended to support community-based living must be visited by a long-term care consultation team within ten working days after the date on which an assessment was requested or recommended. Assessments must be conducted according to paragraphs (b) to (g).

(b) The county may utilize a team of either the social worker or public health nurse, or both, to conduct the assessment in a face-to-face interview. The consultation team members must confer regarding the most appropriate care for each individual screened or assessed.

(c) The long-term care consultation team must assess the health and social needs of the person, using an assessment form provided by the commissioner.

(d) The team must conduct the assessment in a face-to-face interview with the person being assessed and the person's legal representative, if applicable.

(e) The team must provide the person, or the person's legal representative, with written recommendations for facility- or community-based services. The team must document that the most cost-effective alternatives available were offered to the individual. For purposes of this requirement, "cost-effective alternatives" means community services and living arrangements that cost the same as or less than nursing facility care.

(f) If the person chooses to use community-based services, the team must provide the person or the person's legal representative with a written community support plan, regardless of whether the individual is eligible for Minnesota health care programs. The

person may request assistance in developing a community support plan without participating in a complete assessment.

(g) The team must give the person receiving assessment or support planning, or the person's legal representative, materials supplied by the commissioner containing the following information:

(1) the purpose of preadmission screening and assessment;

(2) information about Minnesota health care programs;

(3) the person's freedom to accept or reject the recommendations of the team;

(4) the person's right to confidentiality under the Minnesota Government Data Practices Act, chapter 13; and

(5) the person's right to appeal the decision regarding the need for nursing facility level of care or the county's final decisions regarding public programs eligibility according to section 256.045, subdivision 3.

Subd. 3b. **Transition assistance.** (a) A long-term care consultation team shall provide assistance to persons residing in a nursing facility, hospital, regional treatment center, or intermediate care facility for persons with mental retardation who request or are referred for assistance. Transition assistance must include assessment, community support plan development, referrals to Minnesota health care programs, and referrals to programs that provide assistance with housing.

(b) The county shall develop transition processes with institutional social workers and discharge planners to ensure that:

(1) persons admitted to facilities receive information about transition assistance that is available;

(2) the assessment is completed for persons within ten working days of the date of request or recommendation for assessment; and

(3) there is a plan for transition and follow-up for the individual's return to the community. The plan must require notification of other local agencies when a person who may require assistance is screened by one county for admission to a facility located in another county.

(c) If a person who is eligible for a Minnesota health care program is admitted to a nursing facility, the nursing facility must include a consultation team member or the case manager in the discharge planning process.

Subd. 4. [Repealed, 1Sp2001 c 9 art 4 s 34]

Subd. 4a. **Preadmission screening activities related to nursing facility admissions.** (a) All applicants to Medicaid certified nursing facilities, including certified boarding care facilities, must be screened prior to admission regardless of income, assets, or funding sources for nursing facility care, except as described in subdivision 4b. The purpose of the screening is to determine the need for nursing facility level of care as described in paragraph (d) and to complete activities required under federal law related to mental illness and mental retardation as outlined in paragraph (b).

(b) A person who has a diagnosis or possible diagnosis of mental illness, mental retardation, or a related condition must receive a preadmission screening before admission regardless of the exemptions outlined in subdivision 4b, paragraph (b), to identify the need for further evaluation and specialized services, unless the admission prior to screening is authorized by the local mental health authority or the local developmental disabilities case manager, or unless authorized by the county agency according to Public Law Number 100-508.

The following criteria apply to the preadmission screening:

(1) the county must use forms and criteria developed by the commissioner to identify persons who require referral for further evaluation and determination of the need for specialized services; and

(2) the evaluation and determination of the need for specialized services must be done by:

(i) a qualified independent mental health professional, for persons with a primary or secondary diagnosis of a serious mental illness; or

(ii) a qualified mental retardation professional, for persons with a primary or secondary diagnosis of mental retardation or related conditions. For purposes of this requirement, a qualified mental retardation professional must meet the standards for a qualified mental retardation professional under Code of Federal Regulations, title 42, section 483.430.

(c) The local county mental health authority or the state mental retardation authority under Public Law Numbers 100-203 and 101-508 may prohibit admission to a nursing facility if the individual does not meet the nursing facility level of care criteria or needs specialized services as defined in Public Law Numbers 100-203 and 101-508. For purposes of this section, "specialized services" for a person with mental retardation or a related condition means active treatment as that term is defined under Code of Federal Regulations, title 42, section 483.440 (a)(1).

(d) The determination of the need for nursing facility level of care must be made according to criteria developed by the commissioner. In assessing a person's needs, consultation team members shall have a physician available for consultation and shall consider the assessment of the individual's attending physician, if any. The individual's physician must be included if the physician chooses to participate. Other personnel may be included on the team as deemed appropriate by the county.

Subd. 4b. **Exemptions and emergency admissions.** (a) Exemptions from the federal screening requirements outlined in subdivision 4a, paragraphs (b) and (c), are limited to:

(1) a person who, having entered an acute care facility from a certified nursing facility, is returning to a certified nursing facility; and

(2) a person transferring from one certified nursing facility in Minnesota to another certified nursing facility in Minnesota.

(b) Persons who are exempt from preadmission screening for purposes of level of care determination include:

(1) persons described in paragraph (a);

(2) an individual who has a contractual right to have nursing facility care paid for indefinitely by the veterans' administration;

(3) an individual enrolled in a demonstration project under section 256B.69, subdivision 8, at the time of application to a nursing facility;

(4) an individual currently being served under the alternative care program or under a home and community-based services waiver authorized under section 1915(c) of the federal Social Security Act; and

(5) individuals admitted to a certified nursing facility for a short-term stay, which is expected to be 14 days or less in duration based upon a physician's certification, and who have been assessed and approved for nursing facility admission within the previous six months. This exemption applies only if the consultation team member determines at the time of the initial assessment of the six-month period that it is appropriate to use the nursing facility for short-term stays and that there is an adequate plan of care for return to the home or community-based setting. If a stay exceeds 14 days, the individual must be referred no later than the first county working day following the 14th resident day for a screening, which must be completed within five working days of the referral. The payment limitations in subdivision 7 apply to an individual found at screening to not meet the level of care criteria for admission to a certified nursing facility.

(c) Persons admitted to a Medicaid-certified nursing facility from the community on an emergency basis as described in paragraph (d) or from an acute care facility on a nonworking day must be screened the first working day after admission.

(d) Emergency admission to a nursing facility prior to screening is permitted when all of the following conditions are met:

(1) a person is admitted from the community to a certified nursing or certified boarding care facility during county nonworking hours;

(2) a physician has determined that delaying admission until preadmission screening is completed would adversely affect the person's health and safety;

(3) there is a recent precipitating event that precludes the client from living safely in the community, such as sustaining an injury, sudden onset of acute illness, or a caregiver's inability to continue to provide care;

(4) the attending physician has authorized the emergency placement and has documented the reason that the emergency placement is recommended; and

(5) the county is contacted on the first working day following the emergency admission.

Transfer of a patient from an acute care hospital to a nursing facility is not considered an emergency except for a person who has received hospital services in the following situations: hospital admission for observation, care in an emergency room without hospital admission, or following hospital 24-hour bed care.

Subd. 4c. **Screening requirements.** (a) A person may be screened for nursing facility admission by telephone or in a face-to-face screening interview. Consultation team members shall identify each individual's needs using the following categories:

(1) the person needs no face-to-face screening interview to determine the need for nursing facility level of care based on information obtained from other health care professionals;

(2) the person needs an immediate face-to-face screening interview to determine the need for nursing facility level of care and complete activities required under subdivision 4a; or

(3) the person may be exempt from screening requirements as outlined in subdivision 4b, but will need transitional assistance after admission or in-person follow-along after a return home.

(b) Persons admitted on a nonemergency basis to a Medicaid-certified nursing facility must be screened prior to admission.

(c) The long-term care consultation team shall recommend a case mix classification for persons admitted to a certified nursing facility when sufficient information is received to make that classification. The nursing facility is authorized to conduct all case mix assessments for persons who have been screened prior to admission for whom the county did not recommend a case mix classification. The nursing facility is authorized to conduct all case mix assessments for persons admitted to the facility prior to a preadmission screening. The county retains the responsibility of distributing appropriate case mix forms to the nursing facility.

(d) The county screening or intake activity must include processes to identify persons who may require transition assistance as described in subdivision 3b.

Subd. 4d. **Preadmission screening of individuals under 65 years of age.** (a) It is the policy of the state of Minnesota to ensure that individuals with disabilities or chronic illness are served in the most integrated setting appropriate to their needs and have the necessary information to make informed choices about home and community-based service options.

(b) Individuals under 65 years of age who are admitted to a nursing facility from a hospital must be screened prior to admission as outlined in subdivisions 4a through 4c.

(c) Individuals under 65 years of age who are admitted to nursing facilities with only a telephone screening must receive a face-to-face assessment from the long-term care consultation team member of the county in which the facility is located or from the recipient's county case manager within 20 working days of admission.

(d) At the face-to-face assessment, the long-term care consultation team member or county case manager must perform the activities required under subdivision 3b.

(e) For individuals under 21 years of age, a screening interview which recommends nursing facility admission must be face-to-face and approved by the commissioner before the individual is admitted to the nursing facility.

(f) In the event that an individual under 65 years of age is admitted to a nursing facility on an emergency basis, the county must be notified of the admission on the next working day, and a face-to-face assessment as described in paragraph (c) must be conducted within 20 working days of admission.

(g) At the face-to-face assessment, the long-term care consultation team member or the case manager must present information about home and community-based options so the individual can make informed choices. If the individual chooses home and community-based services, the long-term care consultation team member or case manager must complete a written relocation plan within 20 working days of the visit. The plan shall describe the services needed to move out of the facility and a time line for the move which is designed to ensure a smooth transition to the individual's home and community.

(h) An individual under 65 years of age residing in a nursing facility shall receive a face-to-face assessment at least every 12 months to review the person's service choices and available alternatives unless the individual indicates, in writing, that annual visits are not desired. In this case, the individual must receive a face-to-face assessment at least once every 36 months for the same purposes.

(i) Notwithstanding the provisions of subdivision 6, the commissioner may pay county agencies directly for face-to-face assessments for individuals under 65 years of age who are being considered for placement or residing in a nursing facility.

Subd. 5. **Administrative activity.** The commissioner shall minimize the number of forms required in the provision of long-term care consultation services and shall limit the screening document to items necessary for community support plan approval, reimbursement, program planning, evaluation, and policy development.

Subd. 6. **Payment for long-term care consultation services.** (a) The total payment for each county must be paid monthly by certified nursing facilities in the county. The monthly amount to be paid by each nursing facility for each fiscal year must be determined by dividing the county's annual allocation for long-term care consultation services by 12 to determine the monthly payment and allocating the monthly payment to each nursing facility based on the number of licensed beds in the nursing facility. Payments to counties in which there is no certified nursing facility must be made by increasing the payment rate of the two facilities located nearest to the county seat.

(b) The commissioner shall include the total annual payment determined under paragraph (a) for each nursing facility reimbursed under section 256B.431 or 256B.434 according to section 256B.431, subdivision 2b, paragraph (g), or 256B.435.

(c) In the event of the layaway, delicensure and decertification, or removal from layaway of 25 percent or more of the beds in a facility, the commissioner may adjust the per diem payment amount in paragraph (b) and may adjust the monthly payment amount in paragraph (a). The effective date of an adjustment made under this paragraph shall be on or after the first day of the month following the effective date of the layaway, delicensure and decertification, or removal from layaway.

(d) Payments for long-term care consultation services are available to the county or counties to cover staff salaries and expenses to provide the services described in subdivision 1a. The county shall employ, or contract with other agencies to employ, within the limits of available funding, sufficient personnel to provide long-term care consultation services while meeting the state's long-term care outcomes and objectives as defined in section 256B.0917, subdivision 1. The county shall be accountable for meeting local objectives as approved by the commissioner in the CSSA biennial plan.

(e) Notwithstanding section 256B.0641, overpayments attributable to payment of the screening costs under the medical assistance program may not be recovered from a facility.

(f) The commissioner of human services shall amend the Minnesota medical assistance plan to include reimbursement for the local consultation teams.

(g) The county may bill, as case management services, assessments, support planning, and follow-along provided to persons determined to be eligible for case management under Minnesota health care programs. No individual or family member shall be charged for an initial assessment or initial support plan development provided under subdivision 3a or 3b.

Subd. 7. **Reimbursement for certified nursing facilities.** (a) Medical assistance reimbursement for nursing facilities shall be authorized for a medical assistance recipient only if a preadmission screening has been conducted prior to admission or the county has authorized an exemption. Medical assistance reimbursement for nursing facilities shall not be provided for any recipient who the local screener has determined does not meet the level of care criteria for nursing facility placement or, if indicated, has not had a level II OBRA evaluation as required under the federal Omnibus Budget Reconciliation Act of 1987 completed unless an admission for a recipient with mental illness is approved by the local mental health authority or an admission for a recipient with mental retardation or related condition is approved by the state mental retardation authority.

(b) The nursing facility must not bill a person who is not a medical assistance recipient for resident days that preceded the date of completion of screening activities as required under subdivisions 4a, 4b, and 4c. The nursing facility must include unreimbursed resident days in the nursing facility resident day totals reported to the commissioner.

(c) The commissioner shall make a request to the health care financing administration for a waiver allowing team approval of Medicaid payments for certified nursing facility care. An individual has a choice and makes the final decision between nursing facility placement and community placement after the screening team's recommendation, except as provided in subdivision 4a, paragraph (c).

Subd. 8. [Repealed, 2001 c 161 s 58]

Subd. 9. [Repealed, 1Sp2001 c 9 art 4 s 34]

History: *1Sp2001 c 9 art 3 s 42; art 4 s 4-14*

256B.0912 [Repealed, 1Sp2001 c 9 art 3 s 76]

256B.0913 ALTERNATIVE CARE PROGRAM.

Subdivision 1. **Purpose and goals.** The purpose of the alternative care program is to provide funding for home and community-based services for elderly persons, in order to limit nursing facility placements. The program is designed to support elderly persons in their desire to remain in the community as independently and as long as possible and to support informal caregivers in their efforts to provide care for elderly people. Further, the goals of the program are:

(1) to contain medical assistance expenditures by funding care in the community; and

(2) to maintain the moratorium on new construction of nursing home beds.

Subd. 2. **Eligibility for services.** Alternative care services are available to Minnesotans age 65 or older who are not eligible for medical assistance without a spenddown or waiver obligation but who would be eligible for medical assistance within 180 days of admission to a nursing facility and subject to subdivisions 4 to 13.

Subd. 3. [Repealed, 1Sp2001 c 9 art 4 s 34]

Subd. 4. **Eligibility for funding for services for nonmedical assistance recipients.** (a) Funding for services under the alternative care program is available to persons who meet the following criteria:

(1) the person has been determined by a community assessment under section 256B.0911 to be a person who would require the level of care provided in a nursing facility, but for the provision of services under the alternative care program;

(2) the person is age 65 or older;

(3) the person would be eligible for medical assistance within 180 days of admission to a nursing facility;

(4) the person is not ineligible for the medical assistance program due to an asset transfer penalty;

(5) the person needs services that are not funded through other state or federal funding; and

(6) the monthly cost of the alternative care services funded by the program for this person does not exceed 75 percent of the statewide weighted average monthly nursing facility rate of the case mix resident class to which the individual alternative care client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the recipient's maintenance needs allowance as described in section 256B.0915, subdivision 1d, paragraph (a), until the first day of the state fiscal year in which the resident assessment system, under section 256B.437, for nursing home rate determination is implemented. Effective on the first day of the state fiscal year in which a resident assessment system, under section 256B.437, for nursing home rate determination is implemented and the first day of each subsequent state fiscal year, the monthly cost of alternative care services for this person shall not exceed the alternative care monthly cap for the case mix resident class to which the alternative care client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, which was in effect on the last day of the previous state fiscal year, and adjusted by the greater of any legislatively adopted home and community-based services cost-of-living percentage increase or any legislatively adopted statewide percent rate increase for nursing facilities. This monthly limit does not prohibit the alternative care client from payment for additional services, but in no case may the cost of additional services purchased under this section exceed the difference between the client's monthly service limit defined under section 256B.0915, subdivision 3, and the alternative care program monthly service limit defined in this paragraph. If medical supplies and equipment or environmental modifications are or will be purchased for an alternative care services recipient, the costs may be prorated on a monthly basis for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's other alternative care services exceeds the monthly limit established in this paragraph, the annual cost of the alternative care services shall be determined. In this event, the annual cost of alternative care services shall not exceed 12 times the monthly limit described in this paragraph.

(b) Alternative care funding under this subdivision is not available for a person who is a medical assistance recipient or who would be eligible for medical assistance without a spenddown or waiver obligation. A person whose initial application for medical assistance is being processed may be served under the alternative care program for a period up to 60 days. If the individual is found to be eligible for medical assistance, medical assistance must be billed for services payable under the federally approved elderly waiver plan and delivered from the date the individual was found eligible for the federally approved elderly waiver plan. Notwithstanding this provision, upon federal approval, alternative care funds may not be used to pay for any service the cost of which is payable by medical assistance or which is used by a recipient to meet a medical assistance income spenddown or waiver obligation.

(c) Alternative care funding is not available for a person who resides in a licensed nursing home, certified boarding care home, hospital, or intermediate care facility, except for case management services which are provided in support of the discharge planning process to a nursing home resident or certified boarding care home resident who is ineligible for case management funded by medical assistance.

Subd. 5. **Services covered under alternative care.** (a) Alternative care funding may be used for payment of costs of:

(1) adult foster care;

(2) adult day care;

(3) home health aide;

(4) homemaker services;

(5) personal care;

(6) case management;

(7) respite care;

(8) assisted living;

(9) residential care services;

(10) care-related supplies and equipment;

(11) meals delivered to the home;

(12) transportation;

(13) skilled nursing;

(14) chore services;

(15) companion services;

(16) nutrition services;

(17) training for direct informal caregivers;

(18) telemedicine devices to monitor recipients in their own homes as an alternative to hospital care, nursing home care, or home visits;

(19) other services which includes discretionary funds and direct cash payments to clients, following approval by the commissioner, subject to the provisions of paragraph (j). Total annual payments for "other services" for all clients within a county may not exceed either ten percent of that county's annual alternative care program base allocation or $5,000, whichever is greater. In no case shall this amount exceed the county's total annual alternative care program base allocation; and

(20) environmental modifications.

(b) The county agency must ensure that the funds are not used to supplant services available through other public assistance or services programs.

(c) Unless specified in statute, the service definitions and standards for alternative care services shall be the same as the service definitions and standards specified in the federally approved elderly waiver plan. Except for the county agencies' approval of direct cash payments to clients as described in paragraph (j) or for a provider of supplies and equipment when the monthly cost of the supplies and equipment is less than $250, persons or agencies must be employed by or under a contract with the county agency or the public health nursing agency of the local board of health in order to receive funding under the alternative care program. Supplies and equipment may be purchased from a vendor not certified to participate in the Medicaid program if the cost for the item is less than that of a Medicaid vendor.

(d) The adult foster care rate shall be considered a difficulty of care payment and shall not include room and board. The adult foster care rate shall be negotiated between the county agency and the foster care provider. The alternative care payment for the foster care service in combination with the payment for other alternative care services, including case management, must not exceed the limit specified in subdivision 4, paragraph (a), clause (6).

(e) Personal care services must meet the service standards defined in the federally approved elderly waiver plan, except that a county agency may contract with a client's relative who meets the relative hardship waiver requirement as defined in section 256B.0627, subdivision 4, paragraph (b), clause (10), to provide personal care services if the county agency ensures supervision of this service by a registered nurse or mental health practitioner.

(f) For purposes of this section, residential care services are services which are provided to individuals living in residential care homes. Residential care homes are currently licensed as board and lodging establishments and are registered with the department of health as providing special services under section 157.17 and are not subject to registration under chapter 144D. Residential care services are defined as "supportive services" and "health-related services." "Supportive services" means the provision of up to 24-hour supervision and oversight. Supportive services includes: (1) transportation, when provided by the residential care home only; (2) socialization,

when socialization is part of the plan of care, has specific goals and outcomes established, and is not diversional or recreational in nature; (3) assisting clients in setting up meetings and appointments; (4) assisting clients in setting up medical and social services; (5) providing assistance with personal laundry, such as carrying the client's laundry to the laundry room. Assistance with personal laundry does not include any laundry, such as bed linen, that is included in the room and board rate. "Health-related services" are limited to minimal assistance with dressing, grooming, and bathing and providing reminders to residents to take medications that are self-administered or providing storage for medications, if requested. Individuals receiving residential care services cannot receive homemaking services funded under this section.

(g) For the purposes of this section, "assisted living" refers to supportive services provided by a single vendor to clients who reside in the same apartment building of three or more units which are not subject to registration under chapter 144D and are licensed by the department of health as a class A home care provider or a class E home care provider. Assisted living services are defined as up to 24-hour supervision, and oversight, supportive services as defined in clause (1), individualized home care aide tasks as defined in clause (2), and individualized home management tasks as defined in clause (3) provided to residents of a residential center living in their units or apartments with a full kitchen and bathroom. A full kitchen includes a stove, oven, refrigerator, food preparation counter space, and a kitchen utensil storage compartment. Assisted living services must be provided by the management of the residential center or by providers under contract with the management or with the county.

(1) Supportive services include:

(i) socialization, when socialization is part of the plan of care, has specific goals and outcomes established, and is not diversional or recreational in nature;

(ii) assisting clients in setting up meetings and appointments; and

(iii) providing transportation, when provided by the residential center only.

(2) Home care aide tasks means:

(i) preparing modified diets, such as diabetic or low sodium diets;

(ii) reminding residents to take regularly scheduled medications or to perform exercises;

(iii) household chores in the presence of technically sophisticated medical equipment or episodes of acute illness or infectious disease;

(iv) household chores when the resident's care requires the prevention of exposure to infectious disease or containment of infectious disease; and

(v) assisting with dressing, oral hygiene, hair care, grooming, and bathing, if the resident is ambulatory, and if the resident has no serious acute illness or infectious disease. Oral hygiene means care of teeth, gums, and oral prosthetic devices.

(3) Home management tasks means:

(i) housekeeping;

(ii) laundry;

(iii) preparation of regular snacks and meals; and

(iv) shopping.

Individuals receiving assisted living services shall not receive both assisted living services and homemaking services. Individualized means services are chosen and designed specifically for each resident's needs, rather than provided or offered to all residents regardless of their illnesses, disabilities, or physical conditions. Assisted living services as defined in this section shall not be authorized in boarding and lodging establishments licensed according to sections 157.011 and 157.15 to 157.22.

(h) For establishments registered under chapter 144D, assisted living services under this section means either the services described in paragraph (g) and delivered by a class E home care provider licensed by the department of health or the services described under section 144A.4605 and delivered by an assisted living home care provider or a class A home care provider licensed by the commissioner of health.

(i) Payment for assisted living services and residential care services shall be a monthly rate negotiated and authorized by the county agency based on an individualized service plan for each resident and may not cover direct rent or food costs.

(1) The individualized monthly negotiated payment for assisted living services as described in paragraph (g) or (h), and residential care services as described in paragraph (f), shall not exceed the nonfederal share in effect on July 1 of the state fiscal year for which the rate limit is being calculated of the greater of either the statewide or any of the geographic groups' weighted average monthly nursing facility payment rate of the case mix resident class to which the alternative care eligible client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the maintenance needs allowance as described in section 256B.0915, subdivision 1d, paragraph (a), until the first day of the state fiscal year in which a resident assessment system, under section 256B.437, of nursing home rate determination is implemented. Effective on the first day of the state fiscal year in which a resident assessment system, under section 256B.437, of nursing home rate determination is implemented and the first day of each subsequent state fiscal year, the individualized monthly negotiated payment for the services described in this clause shall not exceed the limit described in this clause which was in effect on the last day of the previous state fiscal year and which has been adjusted by the greater of any legislatively adopted home and community-based services cost-of-living percentage increase or any legislatively adopted statewide percent rate increase for nursing facilities.

(2) The individualized monthly negotiated payment for assisted living services described under section 144A.4605 and delivered by a provider licensed by the department of health as a class A home care provider or an assisted living home care provider and provided in a building that is registered as a housing with services establishment under chapter 144D and that provides 24-hour supervision in combination with the payment for other alternative care services, including case management, must not exceed the limit specified in subdivision 4, paragraph (a), clause (6).

(j) A county agency may make payment from their alternative care program allocation for "other services" which include use of "discretionary funds" for services that are not otherwise defined in this section and direct cash payments to the client for the purpose of purchasing the services. The following provisions apply to payments under this paragraph:

(1) a cash payment to a client under this provision cannot exceed 80 percent of the monthly payment limit for that client as specified in subdivision 4, paragraph (a), clause (6);

(2) a county may not approve any cash payment for a client who meets either of the following:

(i) has been assessed as having a dependency in orientation, unless the client has an authorized representative. An "authorized representative" means an individual who is at least 18 years of age and is designated by the person or the person's legal representative to act on the person's behalf. This individual may be a family member, guardian, representative payee, or other individual designated by the person or the person's legal representative, if any. to assist in purchasing and arranging for supports; or

(ii) is concurrently receiving adult foster care, residential care, or assisted living services;

(3) cash payments to a person or a person's family will be provided through a monthly payment and be in the form of cash, voucher, or direct county payment to a vendor. Fees or premiums assessed to the person for eligibility for health and human services are not reimbursable through this service option. Services and goods purchased through cash payments must be identified in the person's individualized care plan and must meet all of the following criteria:

(i) they must be over and above the normal cost of caring for the person if the person did not have functional limitations;

(ii) they must be directly attributable to the person's functional limitations;

(iii) they must have the potential to be effective at meeting the goals of the program;

(iv) they must be consistent with the needs identified in the individualized service plan. The service plan shall specify the needs of the person and family, the form and amount of payment, the items and services to be reimbursed, and the arrangements for management of the individual grant; and

(v) the person, the person's family, or the legal representative shall be provided sufficient information to ensure an informed choice of alternatives. The local agency shall document this information in the person's care plan, including the type and level of expenditures to be reimbursed;

(4) the county, lead agency under contract, or tribal government under contract to administer the alternative care program shall not be liable for damages, injuries, or liabilities sustained through the purchase of direct supports or goods by the person, the person's family, or the authorized representative with funds received through the cash payments under this section. Liabilities include, but are not limited to, workers' compensation, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA);

(5) persons receiving grants under this section shall have the following responsibilities:

(i) spend the grant money in a manner consistent with their individualized service plan with the local agency;

(ii) notify the local agency of any necessary changes in the grant expenditures;

(iii) arrange and pay for supports; and

(iv) inform the local agency of areas where they have experienced difficulty securing or maintaining supports; and

(6) the county shall report client outcomes, services, and costs under this paragraph in a manner prescribed by the commissioner.

(k) Upon implementation of direct cash payments to clients under this section, any person determined eligible for the alternative care program who chooses a cash payment approved by the county agency shall receive the cash payment under this section and not under section 256.476 unless the person was receiving a consumer support grant under section 256.476 before implementation of direct cash payments under this section.

Subd. 6. **Alternative care program administration.** The alternative care program is administered by the county agency. This agency is the lead agency responsible for the local administration of the alternative care program as described in this section. However, it may contract with the public health nursing service to be the lead agency. The commissioner may contract with federally recognized Indian tribes with a reservation in Minnesota to serve as the lead agency responsible for the local administration of the alternative care program as described in the contract.

Subd. 7. **Case management.** Providers of case management services for persons receiving services funded by the alternative care program must meet the qualification requirements and standards specified in section 256B.0915, subdivision 1b. The case manager must not approve alternative care funding for a client in any setting in which the case manager cannot reasonably ensure the client's health and safety. The case manager is responsible for the cost-effectiveness of the alternative care individual care plan and must not approve any care plan in which the cost of services funded by alternative care and client contributions exceeds the limit specified in section 256B.0915, subdivision 3, paragraph (b). The county may allow a case manager employed by the county to delegate certain aspects of the case management activity to another individual employed by the county provided there is oversight of the individual by the case manager. The case manager may not delegate those aspects which require professional judgment including assessments, reassessments, and care plan development.

Subd. 8. **Requirements for individual care plan.** (a) The case manager shall implement the plan of care for each alternative care client and ensure that a client's service needs and eligibility are reassessed at least every 12 months. The plan shall include any services prescribed by the individual's attending physician as necessary to allow the individual to remain in a community setting. In developing the individual's care plan, the case manager should include the use of volunteers from families and neighbors, religious organizations, social clubs, and civic and service organizations to support the formal home care services. The county shall be held harmless for damages or injuries sustained through the use of volunteers under this subdivision including workers' compensation liability. The lead agency shall provide documentation in each individual's plan of care and, if requested, to the commissioner that the most cost-effective alternatives available have been offered to the individual and that the individual was free to choose among available qualified providers, both public and private. The case manager must give the individual a ten-day written notice of any decrease in or termination of alternative care services.

(b) If the county administering alternative care services is different than the county of financial responsibility, the care plan may be implemented without the approval of the county of financial responsibility.

Subd. 9. **Contracting provisions for providers.** Alternative care funds paid to service providers are subject to audit by the commissioner for fiscal and utilization control.

The lead agency must select providers for contracts or agreements using the following criteria and other criteria established by the county:

(1) the need for the particular services offered by the provider;

(2) the population to be served, including the number of clients, the length of time services will be provided, and the medical condition of clients;

(3) the geographic area to be served;

(4) quality assurance methods, including appropriate licensure, certification, or standards, and supervision of employees when needed;

(5) rates for each service and unit of service exclusive of county administrative costs;

(6) evaluation of services previously delivered by the provider; and

(7) contract or agreement conditions, including billing requirements, cancellation, and indemnification.

The county must evaluate its own agency services under the criteria established for other providers.

Subd. 10. **Allocation formula.** (a) The alternative care appropriation for fiscal years 1992 and beyond shall cover only alternative care eligible clients. Prior to July 1 of each year, the commissioner shall allocate to county agencies the state funds available for alternative care for persons eligible under subdivision 2.

(b) The adjusted base for each county is the county's current fiscal year base allocation plus any targeted funds approved during the current fiscal year. Calculations for paragraphs (c) and (d) are to be made as follows: for each county, the determination of alternative care program expenditures shall be based on payments for services rendered from April 1 through March 31 in the base year, to the extent that claims have been submitted and paid by June 1 of that year.

(c) If the alternative care program expenditures as defined in paragraph (b) are 95 percent or more of the county's adjusted base allocation, the allocation for the next fiscal year is 100 percent of the adjusted base, plus inflation to the extent that inflation is included in the state budget.

(d) If the alternative care program expenditures as defined in paragraph (b) are less than 95 percent of the county's adjusted base allocation, the allocation for the next fiscal year is the adjusted base allocation less the amount of unspent funds below the 95 percent level.

(e) If the annual legislative appropriation for the alternative care program is inadequate to fund the combined county allocations for a biennium, the commissioner shall distribute to each county the entire annual appropriation as that county's percentage of the computed base as calculated in paragraphs (c) and (d).

Subd. 11. **Targeted funding.** (a) The purpose of targeted funding is to make additional money available to counties with the greatest need. Targeted funds are not intended to be distributed equitably among all counties, but rather, allocated to those with long-term care strategies that meet state goals.

(b) The funds available for targeted funding shall be the total appropriation for each fiscal year minus county allocations determined under subdivision 10 as adjusted for any inflation increases provided in appropriations for the biennium.

(c) The commissioner shall allocate targeted funds to counties that demonstrate to the satisfaction of the commissioner that they have developed feasible plans to increase alternative care spending. In making targeted funding allocations, the commissioner shall use the following priorities:

(1) counties that received a lower allocation in fiscal year 1991 than in fiscal year 1990. Counties remain in this priority until they have been restored to their fiscal year 1990 level plus inflation;

(2) counties that sustain a base allocation reduction for failure to spend 95 percent of the allocation if they demonstrate that the base reduction should be restored;

(3) counties that propose projects to divert community residents from nursing home placement or convert nursing home residents to community living; and

(4) counties that can otherwise justify program growth by demonstrating the existence of waiting lists, demographically justified needs, or other unmet needs.

(d) Counties that would receive targeted funds according to paragraph (c) must demonstrate to the commissioner's satisfaction that the funds would be appropriately spent by showing how the funds would be used to further the state's alternative care goals as described in subdivision 1, and that the county has the administrative and service delivery capability to use them.

(e) The commissioner shall request applications for targeted funds by November 1 of each year. The counties selected for targeted funds shall be notified of the amount of their additional funding. Targeted funds allocated to a county agency in one year shall be treated as part of the county's base allocation for that year in determining allocations for subsequent years. No reallocations between counties shall be made.

Subd. 12. **Client premiums.** (a) A premium is required for all alternative care eligible clients to help pay for the cost of participating in the program. The amount of the premium for the alternative care client shall be determined as follows:

(1) when the alternative care client's income less recurring and predictable medical expenses is greater than the recipient's maintenance needs allowance as defined in section 256B.0915, subdivision 1d, paragraph (a), but less than 150 percent of the federal poverty guideline effective on July 1 of the state fiscal year in which the premium is being computed, and total assets are less than $10,000, the fee is zero;

(2) when the alternative care client's income less recurring and predictable medical expenses is greater than 150 percent of the federal poverty guideline effective on July 1 of the state fiscal year in which the premium is being computed, and total assets are less than $10,000, the fee is 25 percent of the cost of alternative care services or the difference between 150 percent of the federal poverty guideline effective on July 1 of the state fiscal year in which the premium is being computed and the client's income less recurring and predictable medical expenses, whichever is less; and

(3) when the alternative care client's total assets are greater than $10,000, the fee is 25 percent of the cost of alternative care services.

For married persons, total assets are defined as the total marital assets less the estimated community spouse asset allowance, under section 256B.059, if applicable. For married persons, total income is defined as the client's income less the monthly spousal allotment, under section 256B.058.

All alternative care services except case management shall be included in the estimated costs for the purpose of determining 25 percent of the costs.

The monthly premium shall be calculated based on the cost of the first full month of alternative care services and shall continue unaltered until the next reassessment is completed or at the end of 12 months, whichever comes first. Premiums are due and payable each month alternative care services are received unless the actual cost of the services is less than the premium.

(b) The fee shall be waived by the commissioner when:

(1) a person who is residing in a nursing facility is receiving case management only;

(2) a person is applying for medical assistance;

(3) a married couple is requesting an asset assessment under the spousal impoverishment provisions;

(4) a person is found eligible for alternative care, but is not yet receiving alternative care services; or

(5) a person's fee under paragraph (a) is less than $25.

(c) The county agency must record in the state's receivable system the client's assessed premium amount or the reason the premium has been waived. The commissioner will bill and collect the premium from the client. Money collected must be deposited in the general fund and is appropriated to the commissioner for the alternative care program. The client must supply the county with the client's social security number at the time of application. The county shall supply the commissioner with the client's social security number and other information the commissioner requires to collect the premium from the client. The commissioner shall collect unpaid premiums using the Revenue Recapture Act in chapter 270A and other methods available to the commissioner. The commissioner may require counties to inform clients of the collection procedures that may be used by the state if a premium is not paid. This paragraph does not apply to alternative care pilot projects authorized in Laws 1993, First Special Session chapter 1, article 5, section 133, if a county operating under the pilot project reports the following dollar amounts to the commissioner quarterly:

(1) total premiums billed to clients;

(2) total collections of premiums billed; and

(3) balance of premiums owed by clients.

If a county does not adhere to these reporting requirements, the commissioner may terminate the billing, collecting, and remitting portions of the pilot project and require the county involved to operate under the procedures set forth in this paragraph.

(d) The commissioner shall begin to adopt emergency or permanent rules governing client premiums within 30 days after July 1, 1991, including criteria for determining when services to a client must be terminated due to failure to pay a premium.

Subd. 13. **County biennial plan.** The county biennial plan for long-term care consultation services under section 256B.0911, the alternative care program under this section, and waivers for the elderly under section 256B.0915, shall be incorporated into the biennial Community Social Services Act plan and shall meet the regulations and timelines of that plan.

Subd. 14. **Payment and rate adjustments.** (a) Payment for provided alternative care services as approved by the client's case manager shall be through the invoice processing procedures of the department's Medicaid Management Information System (MMIS). To receive payment, the county or vendor must submit invoices within 12 months following the date of service. The county agency and its vendors under contract shall not be reimbursed for services which exceed the county allocation.

(b) The county shall negotiate individual rates with vendors and may authorize service payment for actual costs up to the county's current approved rate. Notwithstanding any other rule or statutory provision to the contrary, the commissioner shall not be authorized to increase rates by an annual inflation factor, unless so authorized

by the legislature. To improve access to community services and eliminate payment disparities between the alternative care program and the elderly waiver program, the commissioner shall establish statewide maximum service rate limits and eliminate county-specific service rate limits.

(1) Effective July 1, 2001, for service rate limits, except those in subdivision 5, paragraphs (d) and (i), the rate limit for each service shall be the greater of the alternative care statewide maximum rate or the elderly waiver statewide maximum rate.

(2) Counties may negotiate individual service rates with vendors for actual costs up to the statewide maximum service rate limit.

Subd. 15a. [Repealed, 1Sp2001 c 9 art 4 s 34]

Subd. 15b. [Repealed, 1Sp2001 c 9 art 4 s 34]

Subd. 15c. [Repealed, 1Sp2001 c 9 art 4 s 34]

Subd. 16. [Repealed, 1Sp2001 c 9 art 4 s 34]

History: *1Sp2001 c 9 art 4 s 15-27*

256B.0915 MEDICAID WAIVER FOR HOME AND COMMUNITY-BASED SERVICES FOR THE ELDERLY.

[For text of subds 1 to 1c, see M.S.2000]

Subd. 1d. **Posteligibility treatment of income and resources for elderly waiver.** Notwithstanding the provisions of section 256B.056, the commissioner shall make the following amendment to the medical assistance elderly waiver program effective July 1, 1999, or upon federal approval, whichever is later.

A recipient's maintenance needs will be an amount equal to the Minnesota supplemental aid equivalent rate as defined in section 256I.03, subdivision 5, plus the medical assistance personal needs allowance as defined in section 256B.35, subdivision 1, paragraph (a), when applying posteligibility treatment of income rules to the gross income of elderly waiver recipients, except for individuals whose income is in excess of the special income standard according to Code of Federal Regulations, title 42, section 435.236. Recipient maintenance needs shall be adjusted under this provision each July 1.

[For text of subd 2, see M.S.2000]

Subd. 3. **Limits of cases, rates, payments, and forecasting.** (a) The number of medical assistance waiver recipients that a county may serve must be allocated according to the number of medical assistance waiver cases open on July 1 of each fiscal year. Additional recipients may be served with the approval of the commissioner.

(b) The monthly limit for the cost of waivered services to an individual elderly waiver client shall be the weighted average monthly nursing facility rate of the case mix resident class to which the elderly waiver client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the recipient's maintenance needs allowance as described in subdivision 1d, paragraph (a), until the first day of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented. Effective on the first day of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented and the first day of each subsequent state fiscal year, the monthly limit for the cost of waivered services to an individual elderly waiver client shall be the rate of the case mix resident class to which the waiver client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, in effect on the last day of the previous state fiscal year, adjusted by the greater of any legislatively adopted home and community-based services cost-of-living percentage increase or any legislatively adopted statewide percent rate increase for nursing facilities.

(c) If extended medical supplies and equipment or environmental modifications are or will be purchased for an elderly waiver client, the costs may be prorated for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of

a recipient's waivered services exceeds the monthly limit established in paragraph (b), the annual cost of all waivered services shall be determined. In this event, the annual cost of all waivered services shall not exceed 12 times the monthly limit of waivered services as described in paragraph (b).

(d) For a person who is a nursing facility resident at the time of requesting a determination of eligibility for elderly waivered services, a monthly conversion limit for the cost of elderly waivered services may be requested. The monthly conversion limit for the cost of elderly waiver services shall be the resident class assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, for that resident in the nursing facility where the resident currently resides until July 1 of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented. Effective on July 1 of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented, the monthly conversion limit for the cost of elderly waiver services shall be the per diem nursing facility rate as determined by the resident assessment system as described in section 256B.437 for that resident in the nursing facility where the resident currently resides multiplied by 365 and divided by 12, less the recipient's maintenance needs allowance as described in subdivision 1d. The limit under this clause only applies to persons discharged from a nursing facility after a minimum 30-day stay and found eligible for waivered services on or after July 1, 1997. The following costs must be included in determining the total monthly costs for the waiver client:

(1) cost of all waivered services, including extended medical supplies and equipment and environmental modifications; and

(2) cost of skilled nursing, home health aide, and personal care services reimbursable by medical assistance.

(e) Medical assistance funding for skilled nursing services, private duty nursing, home health aide, and personal care services for waiver recipients must be approved by the case manager and included in the individual care plan.

(f) A county is not required to contract with a provider of supplies and equipment if the monthly cost of the supplies and equipment is less than $250.

(g) The adult foster care rate shall be considered a difficulty of care payment and shall not include room and board. The adult foster care service rate shall be negotiated between the county agency and the foster care provider. The elderly waiver payment for the foster care service in combination with the payment for all other elderly waiver services, including case management, must not exceed the limit specified in paragraph (b).

(h) Payment for assisted living service shall be a monthly rate negotiated and authorized by the county agency based on an individualized service plan for each resident and may not cover direct rent or food costs.

(1) The individualized monthly negotiated payment for assisted living services as described in section 256B.0913, subdivision 5, paragraph (g) or (h), and residential care services as described in section 256B.0913, subdivision 5, paragraph (f), shall not exceed the nonfederal share, in effect on July 1 of the state fiscal year for which the rate limit is being calculated, of the greater of either the statewide or any of the geographic groups' weighted average monthly nursing facility rate of the case mix resident class to which the elderly waiver eligible client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the maintenance needs allowance as described in subdivision 1d, paragraph (a), until the July 1 of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented. Effective on July 1 of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented and July 1 of each subsequent state fiscal year, the individualized monthly negotiated payment for the services described in this clause shall not exceed the limit described in this clause which was in effect on June 30 of the previous state fiscal year and which has been adjusted by the greater of any legislatively adopted

home and community-based services cost-of-living percentage increase or any legislatively adopted statewide percent rate increase for nursing facilities.

(2) The individualized monthly negotiated payment for assisted living services described in section 144A.4605 and delivered by a provider licensed by the department of health as a class A home care provider or an assisted living home care provider and provided in a building that is registered as a housing with services establishment under chapter 144D and that provides 24-hour supervision in combination with the payment for other elderly waiver services, including case management, must not exceed the limit specified in paragraph (b).

(i) The county shall negotiate individual service rates with vendors and may authorize payment for actual costs up to the county's current approved rate. Persons or agencies must be employed by or under a contract with the county agency or the public health nursing agency of the local board of health in order to receive funding under the elderly waiver program, except as a provider of supplies and equipment when the monthly cost of the supplies and equipment is less than $250.

(j) Reimbursement for the medical assistance recipients under the approved waiver shall be made from the medical assistance account through the invoice processing procedures of the department's Medicaid Management Information System (MMIS), only with the approval of the client's case manager. The budget for the state share of the Medicaid expenditures shall be forecasted with the medical assistance budget, and shall be consistent with the approved waiver.

(k) To improve access to community services and eliminate payment disparities between the alternative care program and the elderly waiver, the commissioner shall establish statewide maximum service rate limits and eliminate county-specific service rate limits.

(1) Effective July 1, 2001, for service rate limits, except those described or defined in paragraphs (g) and (h), the rate limit for each service shall be the greater of the alternative care statewide maximum rate or the elderly waiver statewide maximum rate.

(2) Counties may negotiate individual service rates with vendors for actual costs up to the statewide maximum service rate limit.

(l) Beginning July 1, 1991, the state shall reimburse counties according to the payment schedule in section 256.025 for the county share of costs incurred under this subdivision on or after January 1, 1991, for individuals who are receiving medical assistance.

Subd. 3a. [Repealed, 1Sp2001 c 9 art 3 s 76; art 4 s 34]

Subd. 3b. [Repealed, 1Sp2001 c 9 art 3 s 76; art 4 s 34]

Subd. 3c. [Repealed, 1Sp2001 c 9 art 3 s 76; art 4 s 34]

[For text of subd 4, see M.S.2000]

Subd. 5. **Reassessments for waiver clients.** A reassessment of a client served under the elderly waiver must be conducted at least every 12 months and at other times when the case manager determines that there has been significant change in the client's functioning. This may include instances where the client is discharged from the hospital.

[For text of subds 6 and 7, see M.S.2000]

History: *1Sp2001 c 9 art 4 s 28-30*

256B.0916 EXPANSION OF HOME AND COMMUNITY-BASED SERVICES; MANAGEMENT AND ALLOCATION RESPONSIBILITIES.

[For text of subds 1 to 6, see M.S.2000]

Subd. 6a. **Statewide availability of consumer-directed community support services.** (a) The commissioner shall submit to the federal Health Care Financing Administration by August 1, 2001, an amendment to the home and community-based waiver for

persons with mental retardation or related conditions to make consumer-directed community support services available in every county of the state by January 1, 2002.

(b) If a county declines to meet the requirements for provision of consumer-directed community supports, the commissioner shall contract with another county, a group of counties, or a private agency to plan for and administer consumer-directed community supports in that county.

(c) The state of Minnesota, county agencies, tribal governments, or administrative entities under contract to participate in the implementation and administration of the home and community-based waiver for persons with mental retardation or a related condition, shall not be liable for damages, injuries, or liabilities sustained through the purchase of support by the individual, the individual's family, legal representative, or the authorized representative with funds received through the consumer-directed community support service under this section. Liabilities include but are not limited to: workers' compensation liability, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA).

Subd. 7. **Annual report by commissioner.** Beginning November 1, 2001, and each November 1 thereafter, the commissioner shall issue an annual report on county and state use of available resources for the home and community-based waiver for persons with mental retardation or related conditions. For each county or county partnership, the report shall include:

(1) the amount of funds allocated but not used;

(2) the county specific allowed reserve amount approved and used;

(3) the number, ages, and living situations of individuals screened and waiting for services;

(4) the urgency of need for services to begin within one, two, or more than two years for each individual;

(5) the services needed;

(6) the number of additional persons served by approval of increased capacity within existing allocations;

(7) results of action by the commissioner to streamline administrative requirements and improve county resource management; and

(8) additional action that would decrease the number of those eligible and waiting for waivered services.

The commissioner shall specify intended outcomes for the program and the degree to which these specified outcomes are attained.

[For text of subd 8, see M.S.2000]

Subd. 9. **Legal representative participation exception.** The commissioner, in cooperation with representatives of counties, service providers, service recipients, family members, legal representatives and advocates, shall develop criteria to allow legal representatives to be reimbursed for providing specific support services to meet the person's needs when a plan which assures health and safety has been agreed upon and carried out by the legal representative, the person, and the county. Legal representatives providing support under the home and community-based waiver for persons with mental retardation or related conditions or the consumer support grant program pursuant to section 256.476, shall not be considered to have a direct or indirect service provider interest under section 256B.092, subdivision 7, if a health and safety plan which meets the criteria established has been agreed upon and implemented. By August 1, 2001, the commissioner shall submit, for federal approval, amendments to allow legal representatives to provide support and receive reimbursement under the home and community-based waiver plan.

History: *1Sp2001 c 9 art 3 s 43-45*

256B.0917 SENIORS' AGENDA FOR INDEPENDENT LIVING (SAIL) PROJECTS FOR A NEW LONG-TERM CARE STRATEGY.

Subdivision 1. **Purpose, mission, goals, and objectives.** (a) The purpose of implementing seniors' agenda for independent living (SAIL) projects under this section is to demonstrate a new cooperative strategy for the long-term care system in the state of Minnesota.

The projects are part of the initial plan for a 20-year strategy. The mission of the 20-year strategy is to create a new community-based care paradigm for long-term care in Minnesota in order to maximize independence of the older adult population, and to ensure cost-effective use of financial and human resources. The goals for the 20-year strategy are to:

(1) achieve a broad awareness and use of low-cost home care and other residential alternatives to nursing homes;

(2) develop a statewide system of information and assistance to enable easy access to long-term care services;

(3) develop sufficient alternatives to nursing homes to serve the increased number of people needing long-term care;

(4) maintain the moratorium on new construction of nursing home beds and to lower the percentage of elderly persons served in institutional settings; and

(5) build a community-based approach and community commitment to delivering long-term care services for elderly persons in their homes.

(b) The objective for the fiscal years 1994 and 1995 biennial plan is to continue at least four but not more than six projects in anticipation of a statewide program. These projects will continue the process of implementing:

(1) a coordinated planning and administrative process;

(2) a refocused function of the preadmission screening program;

(3) the development of additional home, community, and residential alternatives to nursing homes;

(4) a program to support the informal caregivers for elderly persons;

(5) programs to strengthen the use of volunteers; and

(6) programs to support the building of community commitment to provide long-term care for elderly persons.

The services offered through these projects are available to those who have their own funds to pay for services, as well as to persons who are eligible for medical assistance and to persons who are 180-day eligible clients to the extent authorized in this section.

Subd. 2. **Design of SAIL projects; local long-term care coordinating team.** (a) The commissioner of human services shall contract with SAIL projects in four to six counties or groups of counties to demonstrate the feasibility and cost-effectiveness of a local long-term care strategy that is consistent with the state's long-term care goals identified in subdivision 1. The commissioner shall publish a notice in the State Register announcing the availability of project funding and giving instructions for making an application. The instructions for the application shall identify the amount of funding available for project components.

(b) To be selected for the project, a county board or boards must establish a long-term care coordinating team consisting of county social service agencies, public health nursing service agencies, local boards of health, a representative of local nursing home providers, a representative of local home care providers, and the area agencies on aging in a geographic area which is responsible for:

(1) developing a local long-term care strategy consistent with state goals and objectives;

(2) submitting an application to be selected as a project;

(3) coordinating planning for funds to provide services to elderly persons, including funds received under Title III of the Older Americans Act, Community Social Services Act, Title XX of the Social Security Act and the Local Public Health Act; and

(4) ensuring efficient services provision and nonduplication of funding.

(c) The board or boards shall designate a public agency to serve as the lead agency. The lead agency receives and manages the project funds from the state and is responsible for the implementation of the local strategy. If selected as a project, the local long-term care coordinating team must semiannually evaluate the progress of the local long-term care strategy in meeting state measures of performance and results as established in the contract.

(d) Each member of the local coordinating team must indicate its endorsement of the local strategy. The local long-term care coordinating team may include in its membership other units of government which provide funding for services to the frail elderly. The team must cooperate with consumers and other public and private agencies, including nursing homes, in the geographic area in order to develop and offer a variety of cost-effective services to the elderly and their caregivers.

(e) The board or boards shall apply to be selected as a project. If the project is selected, the commissioner of human services shall contract with the lead agency for the project and shall provide additional administrative funds for implementing the provisions of the contract, within the appropriation available for this purpose.

(f) Projects shall be selected according to the following conditions.

No project may be selected unless it demonstrates that:

(i) the objectives of the local project will help to achieve the state's long-term care goals as defined in subdivision 1;

(ii) in the case of a project submitted jointly by several counties, all of the participating counties are contiguous;

(iii) there is a designated local lead agency that is empowered to make contracts with the state and local vendors on behalf of all participants;

(iv) the project proposal demonstrates that the local cooperating agencies have the ability to perform the project as described and that the implementation of the project has a reasonable chance of achieving its objectives;

(v) the project will serve an area that covers at least four counties or contains at least 2,500 persons who are 85 years of age or older, according to the projections of the state demographer or the census if the data is more recent; and

(vi) the local coordinating team documents efforts of cooperation with consumers and other agencies and organizations, both public and private, in planning for service delivery.

[For text of subds 3 to 6, see M.S.2000]

Subd. 7. **Contract.** (a) The commissioner of human services shall execute a contract with Living at Home/Block Nurse Program, Inc. (LAH/BN, Inc.). The contract shall require LAH/BN, Inc. to:

(1) develop criteria for and award grants to establish community-based organizations that will implement living-at-home/block nurse programs throughout the state;

(2) award grants to enable living-at-home/block nurse programs to continue to implement the combined living-at-home/block nurse program model;

(3) serve as a state technical assistance center to assist and coordinate the living-at-home/block nurse programs established; and

(4) manage contracts with individual living-at-home/block nurse programs.

(b) The contract shall be effective July 1, 1997, and section 16B.17 shall not apply.

[For text of subds 8 to 12, see M.S.2000]

Subd. 13. **Community service grants.** The commissioner shall award contracts for grants to public and private nonprofit agencies to establish services that strengthen a

community's ability to provide a system of home and community-based services for elderly persons. The commissioner shall use a request for proposal process. The commissioner shall give preference when awarding grants under this section to areas where nursing facility closures have occurred or are occurring. The commissioner shall consider grants for:

(1) caregiver support and respite care projects under subdivision 6;

(2) on-site coordination under section 256.9731;

(3) the living-at-home/block nurse grant under subdivisions 7 to 10; and

(4) services identified as needed for community transition.

History: *2001 c 161 s 46,47; 1Sp2001 c 9 art 4 s 31,32*

256B.092 CASE MANAGEMENT OF PERSONS WITH MENTAL RETARDATION OR RELATED CONDITIONS.

[For text of subds 1 to 4c, see M.S.2000]

Subd. 5. **Federal waivers.** (a) The commissioner shall apply for any federal waivers necessary to secure, to the extent allowed by law, federal financial participation under United States Code, title 42, sections 1396 et seq., as amended, for the provision of services to persons who, in the absence of the services, would need the level of care provided in a regional treatment center or a community intermediate care facility for persons with mental retardation or related conditions. The commissioner may seek amendments to the waivers or apply for additional waivers under United States Code, title 42, sections 1396 et seq., as amended, to contain costs. The commissioner shall ensure that payment for the cost of providing home and community-based alternative services under the federal waiver plan shall not exceed the cost of intermediate care services including day training and habilitation services that would have been provided without the waivered services.

(b) The commissioner, in administering home and community-based waivers for persons with mental retardation and related conditions, shall ensure that day services for eligible persons are not provided by the person's residential service provider, unless the person or the person's legal representative is offered a choice of providers and agrees in writing to provision of day services by the residential service provider. The individual service plan for individuals who choose to have their residential service provider provide their day services must describe how health, safety, and protection needs will be met by frequent and regular contact with persons other than the residential service provider.

[For text of subds 6 to 10, see M.S.2000]

History: *1Sp2001 c 9 art 3 s 46*

256B.0924 TARGETED CASE MANAGEMENT SERVICES FOR VULNERABLE ADULTS AND PERSONS WITH DEVELOPMENTAL DISABILITIES.

Subdivision 1. **Purpose.** The state recognizes that targeted case management services can decrease the need for more costly services such as multiple emergency room visits or hospitalizations by linking eligible individuals with less costly services available in the community.

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given:

(a) "Targeted case management" means services which will assist medical assistance eligible persons to gain access to needed medical, social, educational, and other services. Targeted case management does not include therapy, treatment, legal, or outreach services.

(b) "Targeted case management for adults" means activities that coordinate and link social and other services designed to help eligible persons gain access to needed protective services, social, health care, mental health, habilitative, educational, vocational, recreational, advocacy, legal, chemical, health, and other related services.

Subd. 3. **Eligibility.** Persons are eligible to receive targeted case management services under this section if the requirements in paragraphs (a) and (b) are met.

(a) The person must be assessed and determined by the local county agency to:

(1) be age 18 or older;

(2) be receiving medical assistance;

(3) have significant functional limitations; and

(4) be in need of service coordination to attain or maintain living in an integrated community setting.

(b) The person must be a vulnerable adult in need of adult protection as defined in section 626.5572, or is an adult with mental retardation as defined in section 252A.02, subdivision 2, or a related condition as defined in section 252.27, subdivision 1a, and is not receiving home and community-based waiver services.

Subd. 4. **Targeted case management service activities.** (a) For persons with mental retardation or a related condition, targeted case management services must meet the provisions of section 256B.092.

(b) For persons not eligible as a person with mental retardation or a related condition, targeted case management service activities include:

(1) an assessment of the person's need for targeted case management services;

(2) the development of a written personal service plan;

(3) a regular review and revision of the written personal service plan with the recipient and the recipient's legal representative, and others as identified by the recipient, to ensure access to necessary services and supports identified in the plan;

(4) effective communication with the recipient and the recipient's legal representative and others identified by the recipient;

(5) coordination of referrals for needed services with qualified providers;

(6) coordination and monitoring of the overall service delivery to ensure the quality and effectiveness of services;

(7) assistance to the recipient and the recipient's legal representative to help make an informed choice of services;

(8) advocating on behalf of the recipient when service barriers are encountered or referring the recipient and the recipient's legal representative to an independent advocate;

(9) monitoring and evaluating services identified in the personal service plan to ensure personal outcomes are met and to ensure satisfaction with services and service delivery;

(10) conducting face-to-face monitoring with the recipient at least twice a year;

(11) completing and maintaining necessary documentation that supports and verifies the activities in this section;

(12) coordinating with the medical assistance facility discharge planner in the 180-day period prior to the recipient's discharge into the community; and

(13) a personal service plan developed and reviewed at least annually with the recipient and the recipient's legal representative. The personal service plan must be revised when there is a change in the recipient's status. The personal service plan must identify:

(i) the desired personal short and long-term outcomes;

(ii) the recipient's preferences for services and supports, including development of a person-centered plan if requested; and

(iii) formal and informal services and supports based on areas of assessment, such as: social, health, mental health, residence, family, educational and vocational, safety, legal, self-determination, financial, and chemical health as determined by the recipient and the recipient's legal representative and the recipient's support network.

Subd. 5. **Provider standards.** County boards or providers who contract with the county are eligible to receive medical assistance reimbursement for adult targeted case

management services. To qualify as a provider of targeted case management services the vendor must:

(1) have demonstrated the capacity and experience to provide the activities of case management services defined in subdivision 4;

(2) be able to coordinate and link community resources needed by the recipient;

(3) have the administrative capacity and experience to serve the eligible population in providing services and to ensure quality of services under state and federal requirements;

(4) have a financial management system that provides accurate documentation of services and costs under state and federal requirements;

(5) have the capacity to document and maintain individual case records complying with state and federal requirements;

(6) coordinate with county social service agencies responsible for planning for community social services under chapters 256E and 256F; conducting adult protective investigations under section 626.557, and conducting prepetition screenings for commitments under section 253B.07;

(7) coordinate with health care providers to ensure access to necessary health care services;

(8) have a procedure in place that notifies the recipient and the recipient's legal representative of any conflict of interest if the contracted targeted case management service provider also provides the recipient's services and supports and provides information on all potential conflicts of interest and obtains the recipient's informed consent and provides the recipient with alternatives; and

(9) have demonstrated the capacity to achieve the following performance outcomes: access, quality, and consumer satisfaction.

Subd. 6. **Payment for targeted case management.** (a) Medical assistance and MinnesotaCare payment for targeted case management shall be made on a monthly basis. In order to receive payment for an eligible adult, the provider must document at least one contact per month and not more than two consecutive months without a face-to-face contact with the adult or the adult's legal representative.

(b) Payment for targeted case management provided by county staff under this subdivision shall be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph (b), calculated as one combined average rate together with adult mental health case management under section 256B.0625, subdivision 20, except for calendar year 2002. In calendar year 2002, the rate for case management under this section shall be the same as the rate for adult mental health case management in effect as of December 31, 2001. Billing and payment must identify the recipient's primary population group to allow tracking of revenues.

(c) Payment for targeted case management provided by county-contracted vendors shall be based on a monthly rate negotiated by the host county. The negotiated rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the county may negotiate a team rate with a vendor who is a member of the team. The team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county, except to reimburse the county for advance funding provided by the county to the vendor.

(d) If the service is provided by a team that includes contracted vendors and county staff, the costs for county staff participation on the team shall be included in the rate for county-provided services. In this case, the contracted vendor and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, the county must document, in the recipient's file, the need for team targeted case management and a description of the different roles of the team members.

(e) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for targeted case management shall be provided by the recipient's county of responsi-

bility, as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds used to match other federal funds.

(f) The commissioner may suspend, reduce, or terminate reimbursement to a provider that does not meet the reporting or other requirements of this section. The county of responsibility, as defined in sections 256G.01 to 256G.12, is responsible for any federal disallowances. The county may share this responsibility with its contracted vendors.

(g) The commissioner shall set aside five percent of the federal funds received under this section for use in reimbursing the state for costs of developing and implementing this section.

(h) Notwithstanding section 256.025, subdivision 2, payments to counties for targeted case management expenditures under this section shall only be made from federal earnings from services provided under this section. Payments to contracted vendors shall include both the federal earnings and the county share.

(i) Notwithstanding section 256B.041, county payments for the cost of case management services provided by county staff shall not be made to the state treasurer. For the purposes of targeted case management services provided by county staff under this section, the centralized disbursement of payments to counties under section 256B.041 consists only of federal earnings from services provided under this section.

(j) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital, and the recipient's institutional care is paid by medical assistance, payment for targeted case management services under this subdivision is limited to the last 180 days of the recipient's residency in that facility and may not exceed more than six months in a calendar year.

(k) Payment for targeted case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

(l) Any growth in targeted case management services and cost increases under this section shall be the responsibility of the counties.

Subd. 7. **Implementation and evaluation.** The commissioner of human services in consultation with county boards shall establish a program to accomplish the provisions of subdivisions 1 to 6. The commissioner in consultation with county boards shall establish performance measures to evaluate the effectiveness of the targeted case management services. If a county fails to meet agreed upon performance measures, the commissioner may authorize contracted providers other than the county. Providers contracted by the commissioner shall also be subject to the standards in subdivision 6.

History: *1Sp2001 c 9 art 2 s 44*

256B.093 SERVICES FOR PERSONS WITH TRAUMATIC BRAIN INJURIES.

Subdivision 1. **State traumatic brain injury program.** The commissioner of human services shall:

(1) maintain a statewide traumatic brain injury program;

(2) supervise and coordinate services and policies for persons with traumatic brain injuries;

(3) contract with qualified agencies or employ staff to provide statewide administrative case management and consultation;

(4) maintain an advisory committee to provide recommendations in reports to the commissioner regarding program and service needs of persons with traumatic brain injuries;

(5) investigate the need for the development of rules or statutes for the traumatic brain injury home and community-based services waiver;

(6) investigate present and potential models of service coordination which can be delivered at the local level; and

(7) the advisory committee required by clause (4) must consist of no fewer than ten members and no more than 30 members. The commissioner shall appoint all

advisory committee members to one- or two-year terms and appoint one member as chair. Notwithstanding section 15.059, subdivision 5, the advisory committee does not terminate until June 30, 2005.

[For text of subd 2, see M.S.2000]

Subd. 3. **Traumatic brain injury program duties.** The department shall fund administrative case management under this subdivision using medical assistance administrative funds. The traumatic brain injury program duties include:

(1) recommending to the commissioner in consultation with the medical review agent according to Minnesota Rules, parts 9505.0500 to 9505.0540, the approval or denial of medical assistance funds to pay for out-of-state placements for traumatic brain injury services and in-state traumatic brain injury services provided by designated Medicare long-term care hospitals;

(2) coordinating the traumatic brain injury home and community-based waiver;

(3) providing ongoing technical assistance and consultation to county and facility case managers to facilitate care plan development for appropriate, accessible, and cost-effective medical assistance services;

(4) providing technical assistance to promote statewide development of appropriate, accessible, and cost-effective medical assistance services and related policy;

(5) providing training and outreach to facilitate access to appropriate home and community-based services to prevent institutionalization;

(6) facilitating appropriate admissions, continued stay review, discharges, and utilization review for neurobehavioral hospitals and other specialized institutions;

(7) providing technical assistance on the use of prior authorization of home care services and coordination of these services with other medical assistance services;

(8) developing a system for identification of nursing facility and hospital residents with traumatic brain injury to assist in long-term planning for medical assistance services. Factors will include, but are not limited to, number of individuals served, length of stay, services received, and barriers to community placement; and

(9) providing information, referral, and case consultation to access medical assistance services for recipients without a county or facility case manager. Direct access to this assistance may be limited due to the structure of the program.

[For text of subds 3a and 4, see M.S.2000]

History: *2001 c 161 s 48; 1Sp2001 c 9 art 3 s 47*

256B.094 CHILD WELFARE TARGETED CASE MANAGEMENT SERVICES.

[For text of subds 1 to 5, see M.S.2000]

Subd. 6. **Medical assistance reimbursement of case management services.** (a) Medical assistance reimbursement for services under this section shall be made on a monthly basis. Payment is based on face-to-face or telephone contacts between the case manager and the client, client's family, primary caregiver, legal representative, or other relevant person identified as necessary to the development or implementation of the goals of the individual service plan regarding the status of the client, the individual service plan, or the goals for the client. These contacts must meet the minimum standards in clauses (1) and (2):

(1) there must be a face-to-face contact at least once a month except as provided in clause (2); and

(2) for a client placed outside of the county of financial responsibility, or a client served by tribal social services placed outside the reservation, in an excluded time facility under section 256G.02, subdivision 6, or through the Interstate Compact on the Placement of Children, section 260.851, and the placement in either case is more than 60 miles beyond the county or reservation boundaries, there must be at least one

contact per month and not more than two consecutive months without a face-to-face contact.

(b) Except as provided under paragraph (c), the payment rate is established using time study data on activities of provider service staff and reports required under sections 245.482, 256.01, subdivision 2, paragraph (17), and 256E.08, subdivision 8.

(c) Payments for tribes may be made according to section 256B.0625 or other relevant federally approved rate setting methodology for child welfare targeted case management provided by Indian health services and facilities operated by a tribe or tribal organization.

(d) Payment for case management provided by county or tribal social services contracted vendors shall be based on a monthly rate negotiated by the host county or tribal social services. The negotiated rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the county or tribal social services may negotiate a team rate with a vendor who is a member of the team. The team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county or tribal social services, except to reimburse the county or tribal social services for advance funding provided by the county or tribal social services to the vendor.

(e) If the service is provided by a team that includes contracted vendors and county or tribal social services staff, the costs for county or tribal social services staff participation in the team shall be included in the rate for county or tribal social services provided services. In this case, the contracted vendor and the county or tribal social services may each receive separate payment for services provided by each entity in the same month. To prevent duplication of services, each entity must document, in the recipient's file, the need for team case management and a description of the roles and services of the team members.

Separate payment rates may be established for different groups of providers to maximize reimbursement as determined by the commissioner. The payment rate will be reviewed annually and revised periodically to be consistent with the most recent time study and other data. Payment for services will be made upon submission of a valid claim and verification of proper documentation described in subdivision 7. Federal administrative revenue earned through the time study, or under paragraph (c), shall be distributed according to earnings, to counties, reservations, or groups of counties or reservations which have the same payment rate under this subdivision, and to the group of counties or reservations which are not certified providers under section 256F.10. The commissioner shall modify the requirements set out in Minnesota Rules, parts 9550.0300 to 9550.0370, as necessary to accomplish this.

[For text of subd 7, see M.S.2000]

Subd. 8. **Payment limitation.** Services that are not eligible for payment as a child welfare targeted case management service include, but are not limited to:

(1) assessments prior to opening a case;

(2) therapy and treatment services;

(3) legal services, including legal advocacy, for the client;

(4) information and referral services that are part of a county's community social services plan, that are not provided to an eligible recipient;

(5) outreach services including outreach services provided through the community support services program;

(6) services that are not documented as required under subdivision 7 and Minnesota Rules, parts 9505.2165 and 9505.2175;

(7) services that are otherwise eligible for payment on a separate schedule under rules of the department of human services;

(8) services to a client that duplicate the same case management service from another case manager;

(9) case management services provided to patients or residents in a medical assistance facility except as described under subdivision 2, clause (9); and

(10) for children in foster care, group homes, or residential care, payment for case management services is limited to case management services that focus on permanency planning or return to the family home and that do not duplicate the facility's discharge planning services.

History: *2001 c 203 s 11,12*

256B.095 QUALITY ASSURANCE PROJECT ESTABLISHED.

Effective July 1, 1998, an alternative quality assurance licensing system project for programs for persons with developmental disabilities is established in Dodge, Fillmore, Freeborn, Goodhue, Houston, Mower, Olmsted, Rice, Steele, Wabasha, and Winona counties for the purpose of improving the quality of services provided to persons with developmental disabilities. A county, at its option, may choose to have all programs for persons with developmental disabilities located within the county licensed under chapter 245A using standards determined under the alternative quality assurance licensing system project or may continue regulation of these programs under the licensing system operated by the commissioner. The project expires on June 30, 2005.

History: *1Sp2001 c 9 art 3 s 48*

256B.0951 QUALITY ASSURANCE COMMISSION.

Subdivision 1. **Membership.** The region 10 quality assurance commission is established. The commission consists of at least 14 but not more than 21 members as follows: at least three but not more than five members representing advocacy organizations; at least three but not more than five members representing consumers, families, and their legal representatives; at least three but not more than five members representing service providers; at least three but not more than five members representing counties; and the commissioner of human services or the commissioner's designee. Initial membership of the commission shall be recruited and approved by the region 10 stakeholders group. Prior to approving the commission's membership, the stakeholders group shall provide to the commissioner a list of the membership in the stakeholders group, as of February 1, 1997, a brief summary of meetings held by the group since July 1, 1996, and copies of any materials prepared by the group for public distribution. The first commission shall establish membership guidelines for the transition and recruitment of membership for the commission's ongoing existence. Members of the commission who do not receive a salary or wages from an employer for time spent on commission duties may receive a per diem payment when performing commission duties and functions. All members may be reimbursed for expenses related to commission activities. Notwithstanding the provisions of section 15.059, subdivision 5, the commission expires on June 30, 2005.

[For text of subd 2, see M.S.2000]

Subd. 3. **Commission duties.** (a) By October 1, 1997, the commission, in cooperation with the commissioners of human services and health, shall do the following: (1) approve an alternative quality assurance licensing system based on the evaluation of outcomes; (2) approve measurable outcomes in the areas of health and safety, consumer evaluation, education and training, providers, and systems that shall be evaluated during the alternative licensing process; and (3) establish variable licensure periods not to exceed three years based on outcomes achieved. For purposes of this subdivision, "outcome" means the behavior, action, or status of a person that can be observed or measured and can be reliably and validly determined.

(b) By January 15, 1998, the commission shall approve, in cooperation with the commissioner of human services, a training program for members of the quality assurance teams established under section 256B.0952, subdivision 4.

(c) The commission and the commissioner shall establish an ongoing review process for the alternative quality assurance licensing system. The review shall take into

account the comprehensive nature of the alternative system, which is designed to evaluate the broad spectrum of licensed and unlicensed entities that provide services to clients, as compared to the current licensing system.

(d) The commission shall contract with an independent entity to conduct a financial review of the alternative quality assurance project. The review shall take into account the comprehensive nature of the alternative system, which is designed to evaluate the broad spectrum of licensed and unlicensed entities that provide services to clients, as compared to the current licensing system. The review shall include an evaluation of possible budgetary savings within the department of human services as a result of implementation of the alternative quality assurance project. If a federal waiver is approved under subdivision 7, the financial review shall also evaluate possible savings within the department of health. This review must be completed by December 15, 2000.

(e) The commission shall submit a report to the legislature by January 15, 2001, on the results of the review process for the alternative quality assurance project, a summary of the results of the independent financial review, and a recommendation on whether the project should be extended beyond June 30, 2001.

(f) The commissioner, in consultation with the commission, shall examine the feasibility of expanding the project to other populations or geographic areas and identify barriers to expansion. The commissioner shall report findings and recommendations to the legislature by December 15, 2004.

Subd. 4. **Commission's authority to recommend variances of licensing standards.** The commission may recommend to the commissioners of human services and health variances from the standards governing licensure of programs for persons with developmental disabilities in order to improve the quality of services by implementing an alternative developmental disabilities licensing system if the commission determines that the alternative licensing system does not adversely affect the health or safety of persons being served by the licensed program nor compromise the qualifications of staff to provide services.

Subd. 5. **Variance of certain standards prohibited.** The safety standards, rights, or procedural protections under sections 245.825; 245.91 to 245.97; 245A.04, subdivisions 3, 3a, 3b, and 3c; 245A.09, subdivision 2, paragraph (c), clauses (2) and (5); 245A.12; 245A.13; 252.41, subdivision 9; 256B.092, subdivisions 1b, clause (7), and 10; 626.556; 626.557, and procedures for the monitoring of psychotropic medications shall not be varied under the alternative licensing system project. The commission may make recommendations to the commissioners of human services and health or to the legislature regarding alternatives to or modifications of the rules and procedures referenced in this subdivision.

Subd. 6. [Repealed, 1Sp2001 c 9 art 3 s 76]

Subd. 7. **Waiver of rules.** The commissioner of health may exempt residents of intermediate care facilities for persons with mental retardation (ICFs/MR) who participate in the three-year quality assurance pilot project established in section 256B.095 from the requirements of Minnesota Rules, chapter 4665, upon approval by the federal government of a waiver of federal certification requirements for ICFs/MR.

Subd. 8. **Federal waiver.** The commissioner of human services shall seek federal authority to waive provisions of intermediate care facilities for persons with mental retardation (ICFs/MR) regulations to enable the demonstration and evaluation of the alternative quality assurance system for ICFs/MR under the project. The commissioner of human services shall apply for any necessary waivers as soon as practicable.

Subd. 9. **Evaluation.** The commission, in consultation with the commissioner of human services, shall conduct an evaluation of the alternative quality assurance system, and present a report to the commissioner by June 30, 2004.

History: *1Sp2001 c 9 art 3 s 49-55*

256B.0952 COUNTY DUTIES; QUALITY ASSURANCE TEAMS.

Subdivision 1. **Notification.** For each year of the project, region 10 counties shall give notice to the commission and commissioners of human services and health by March 15 of intent to join the quality assurance alternative licensing system, effective July 1 of that year. A county choosing to participate in the alternative licensing system commits to participate until June 30, 2005. Counties participating in the quality assurance alternative licensing system as of January 1, 2001, shall notify the commission and the commissioners of human services and health by March 15, 2001, of intent to continue participation. Counties that elect to continue participation must participate in the alternative licensing system until June 30, 2005.

[For text of subds 2 and 3, see M.S.2000]

Subd. 4. **Appointment of quality assurance manager.** (a) A county or group of counties that chooses to participate in the alternative licensing system shall designate a quality assurance manager and shall establish quality assurance teams in accordance with subdivision 5. The manager shall recruit, train, and assign duties to the quality assurance team members. In assigning team members to conduct the quality assurance process at a facility, program, or service, the manager shall take into account the size of the service provider, the number of services to be reviewed, the skills necessary for team members to complete the process, and other relevant factors. The manager shall ensure that no team member has a financial, personal, or family relationship with the facility, program, or service being reviewed or with any clients of the facility, program, or service.

(b) Quality assurance teams shall report the findings of their quality assurance reviews to the quality assurance manager. The quality assurance manager shall provide the report from the quality assurance team to the county and, upon request, to the commissioners of human services and health, and shall provide a summary of the report to the quality assurance review council.

[For text of subds 5 and 6, see M.S.2000]

History: *1Sp2001 c 9 art 3 s 56,57*

256B.15 CLAIMS AGAINST ESTATES.

[For text of subds 1 and 1a, see M.S.2000]

Subd. 1b. [Repealed, 2001 c 203 s 19]

[For text of subd 2, see M.S.2000]

Subd. 2a. [Repealed, 2001 c 203 s 19]

[For text of subds 3 to 5, see M.S.2000]

256B.19 DIVISION OF COST.

[For text of subds 1 and 1a, see M.S.2000]

Subd. 1b. [Repealed, 1Sp2001 c 9 art 2 s 76]

Subd. 1c. **Additional portion of nonfederal share.** (a) Hennepin county shall be responsible for a monthly transfer payment of $1,500,000, due before noon on the 15th of each month and the University of Minnesota shall be responsible for a monthly transfer payment of $500,000 due before noon on the 15th of each month, beginning July 15, 1995. These sums shall be part of the designated governmental unit's portion of the nonfederal share of medical assistance costs, but shall not be subject to payback provisions of section 256.025.

(b) Beginning July 1, 2001, Hennepin county's payment under paragraph (a) shall be $2,066,000 each month.

(c) Beginning July 1, 2001, the commissioner shall increase annual capitation payments to the metropolitan health plan under section 256B.69 for the prepaid

medical assistance program by approximately $3,400,000, plus any available federal matching funds, to recognize higher than average medical education costs.

[For text of subds 1d to 3, see M.S.2000]

History: *1Sp2001 c 9 art 2 s 45*

256B.195 ADDITIONAL INTERGOVERNMENTAL TRANSFERS; HOSPITAL PAYMENTS.

Subdivision 1. **Federal approval required.** Sections 145.9268, 256.969, subdivision 26, and this section are contingent on federal approval of the intergovernmental transfers and payments to safety net hospitals and community clinics authorized under this section. These sections are also contingent on current payment, by the government entities, of intergovernmental transfers under section 256B.19 and this section.

Subd. 2. **Payments from governmental entities.** (a) In addition to any payment required under section 256B.19, effective July 15, 2001, the following government entities shall make the payments indicated before noon on the 15th of each month:

(1) Hennepin county, $2,000,000; and

(2) Ramsey county, $1,000,000.

(b) These sums shall be part of the designated governmental unit's portion of the nonfederal share of medical assistance costs. Of these payments, Hennepin county shall pay 71 percent directly to Hennepin County Medical Center, and Ramsey county shall pay 71 percent directly to Regions hospital. The counties must provide certification to the commissioner of payments to hospitals under this subdivision.

Subd. 3. **Payments to certain safety net providers.** (a) Effective July 15, 2001, the commissioner shall make the following payments to the hospitals indicated after noon on the 15th of each month:

(1) to Hennepin County Medical Center, any federal matching funds available to match the payments received by the medical center under subdivision 2, to increase payments for medical assistance admissions and to recognize higher medical assistance costs in institutions that provide high levels of charity care; and

(2) to Regions hospital, any federal matching funds available to match the payments received by the hospital under subdivision 2, to increase payments for medical assistance admissions and to recognize higher medical assistance costs in institutions that provide high levels of charity care.

(b) Effective July 15, 2001, the following percentages of the transfers under subdivision 2 shall be retained by the commissioner for deposit each month into the general fund:

(1) 18 percent, plus any federal matching funds, shall be allocated for the following purposes:

(i) during the fiscal year beginning July 1, 2001, of the amount available under this clause, 39.7 percent shall be allocated to make increased hospital payments under section 256.969, subdivision 26; 34.2 percent shall be allocated to fund the amounts due from small rural hospitals, as defined in section 144.148, for overpayments under section 256.969, subdivision 5a, resulting from a determination that medical assistance and general assistance payments exceeded the charge limit during the period from 1994 to 1997; and 26.1 percent shall be allocated to the commissioner of health for rural hospital capital improvement grants under section 144.148; and

(ii) during fiscal years beginning on or after July 1, 2002, of the amount available under this clause, 55 percent shall be allocated to make increased hospital payments under section 256.969, subdivision 26, and 45 percent shall be allocated to the commissioner of health for rural hospital capital improvement grants under section 144.148; and

(2) 11 percent shall be allocated to the commissioner of health to fund community clinic grants under section 145.9268.

(c) This subdivision shall apply to fee-for-service payments only and shall not increase capitation payments or payments made based on average rates.

(d) Medical assistance rate or payment changes, including those required to obtain federal financial participation under section 62J.692, subdivision 8, shall precede the determination of intergovernmental transfer amounts determined in this subdivision. Participation in the intergovernmental transfer program shall not result in the offset of any health care provider's receipt of medical assistance payment increases other than limits resulting from hospital-specific charge limits and limits on disproportionate share hospital payments.

Subd. 4. **Adjustments permitted.** (a) The commissioner may adjust the intergovernmental transfers under subdivision 2 and the payments under subdivision 3, and payments and transfers under subdivision 5, based on the commissioner's determination of Medicare upper payment limits, hospital-specific charge limits, and hospital-specific limitations on disproportionate share payments. Any adjustments must be made on a proportional basis. If participation by a particular hospital under this section is limited, the commissioner shall adjust the payments that relate to that hospital under subdivisions 2, 3, and 5 on a proportional basis in order to allow the hospital to participate under this section to the fullest extent possible and shall increase other payments under subdivisions 2, 3, and 5 to the extent allowable to maintain the overall level of payments under this section. The commissioner may make adjustments under this subdivision only after consultation with the counties and hospitals identified in subdivisions 2 and 3, and, if subdivision 5 receives federal approval, with the hospital and educational institution identified in subdivision 5.

(b) The ratio of medical assistance payments specified in subdivision 3 to the intergovernmental transfers specified in subdivision 2 shall not be reduced except as provided under paragraph (a).

Subd. 5. **Inclusion of Fairview University Medical Center.** (a) Upon federal approval of the inclusion of Fairview University Medical Center in the nonstate government category, the commissioner shall establish an intergovernmental transfer with the University of Minnesota in an amount determined by the commissioner based on the increase in the Medicare upper payment limit due solely to the inclusion of Fairview University Medical Center as a nonstate government hospital and limited by hospital-specific charge limits and the amount available under the hospital-specific disproportionate share limit.

(b) The commissioner shall increase payments for medical assistance admissions at Fairview University Medical Center by 71 percent of the transfer plus any federal matching payments on that amount, to increase payments for medical assistance admissions and to recognize higher medical assistance costs in institutions that provide high levels of charity care. From this payment, Fairview University Medical Center shall pay to the University of Minnesota the cost of the transfer, on the same day the payment is received. Eighteen percent of the transfer plus any federal matching payments shall be used as specified in subdivision 3, paragraph (b), clause (1). Payments under section 256.969, subdivision 26, may be increased above the 90 percent level specified in that subdivision within the limits of additional funding available under this subdivision. Eleven percent of the transfer shall be used to increase the grants under section 145.9268.

History: *1Sp2001 c 9 art 2 s 46*

256B.431 RATE DETERMINATION.

[For text of subds 1 to 2d, see M.S.2000]

Subd. 2e. **Contracts for services for ventilator-dependent persons.** The commissioner may contract with a nursing facility eligible to receive medical assistance payments to provide services to a ventilator-dependent person identified by the commissioner according to criteria developed by the commissioner, including:

(1) nursing facility care has been recommended for the person by a preadmission screening team;

(2) the person has been hospitalized and no longer requires inpatient acute care hospital services; and

(3) the commissioner has determined that necessary services for the person cannot be provided under existing nursing facility rates.

The commissioner may issue a request for proposals to provide services to a ventilator-dependent person to nursing facilities eligible to receive medical assistance payments and shall select nursing facilities from among respondents according to criteria developed by the commissioner, including:

(1) the cost-effectiveness and appropriateness of services;

(2) the nursing facility's compliance with federal and state licensing and certification standards; and

(3) the proximity of the nursing facility to a ventilator-dependent person identified by the commissioner who requires nursing facility placement.

The commissioner may negotiate an adjustment to the operating cost payment rate for a nursing facility selected by the commissioner from among respondents to the request for proposals. The negotiated adjustment must reflect only the actual additional cost of meeting the specialized care needs of a ventilator-dependent person identified by the commissioner for whom necessary services cannot be provided under existing nursing facility rates and which are not otherwise covered under Minnesota Rules, parts 9549.0010 to 9549.0080 or 9505.0170 to 9505.0475. For persons who are initially admitted to a nursing facility before July 1, 2001, and have their payment rate under this subdivision negotiated after July 1, 2001, the negotiated payment rate must not exceed 200 percent of the highest multiple bedroom payment rate for the facility, as initially established by the commissioner for the rate year for case mix classification K. For persons initially admitted to a nursing facility on or after July 1, 2001, the negotiated payment rate must not exceed 300 percent of the facility's multiple bedroom payment rate for case mix classification K. The negotiated adjustment shall not affect the payment rate charged to private paying residents under the provisions of section 256B.48, subdivision 1.

[For text of subds 2g to 16, see M.S.2000]

Subd. 17. **Special provisions for moratorium exceptions.** (a) Notwithstanding Minnesota Rules, part 9549.0060, subpart 3, for rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, a nursing facility that (1) has completed a construction project approved under section 144A.071, subdivision 4a, clause (m); (2) has completed a construction project approved under section 144A.071, subdivision 4a, and effective after June 30, 1995; or (3) has completed a renovation, replacement, or upgrading project approved under the moratorium exception process in section 144A.073 shall be reimbursed for costs directly identified to that project as provided in subdivision 16 and this subdivision.

(b) Notwithstanding Minnesota Rules, part 9549.0060, subparts 5, item A, subitems (1) and (3), and 7, item D, allowable interest expense on debt shall include:

(1) interest expense on debt related to the cost of purchasing or replacing depreciable equipment, excluding vehicles, not to exceed six percent of the total historical cost of the project; and

(2) interest expense on debt related to financing or refinancing costs, including costs related to points, loan origination fees, financing charges, legal fees, and title searches; and issuance costs including bond discounts, bond counsel, underwriter's counsel, corporate counsel, printing, and financial forecasts. Allowable debt related to items in this clause shall not exceed seven percent of the total historical cost of the project. To the extent these costs are financed, the straight-line amortization of the costs in this clause is not an allowable cost; and

(3) interest on debt incurred for the establishment of a debt reserve fund, net of the interest earned on the debt reserve fund.

(c) Debt incurred for costs under paragraph (b) is not subject to Minnesota Rules, part 9549.0060, subpart 5, item A, subitem (5) or (6).

(d) The incremental increase in a nursing facility's rental rate, determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section, resulting from the acquisition of allowable capital assets, and allowable debt and interest expense under this subdivision shall be added to its property-related payment rate and shall be effective on the first day of the month following the month in which the moratorium project was completed.

(e) Notwithstanding subdivision 3f, paragraph (a), for rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, the replacement-costs-new per bed limit to be used in Minnesota Rules, part 9549.0060, subpart 4, item B, for a nursing facility that has completed a renovation, replacement, or upgrading project that has been approved under the moratorium exception process in section 144A.073, or that has completed an addition to or replacement of buildings, attached fixtures, or land improvements for which the total historical cost exceeds the lesser of $150,000 or ten percent of the most recent appraised value, must be $47,500 per licensed bed in multiple-bed rooms and $71,250 per licensed bed in a single-bed room. These amounts must be adjusted annually as specified in subdivision 3f, paragraph (a), beginning January 1, 1993.

(f) For purposes of this paragraph, a total replacement means the complete replacement of the nursing facility's physical plant through the construction of a new physical plant, the transfer of the nursing facility's license from one physical plant location to another, or a new building addition to relocate beds from three- and four-bed wards. For total replacement projects completed on or after July 1, 1992, the commissioner shall compute the incremental change in the nursing facility's rental per diem, for rate years beginning on or after July 1, 1995, by replacing its appraised value, including the historical capital asset costs, and the capital debt and interest costs with the new nursing facility's allowable capital asset costs and the related allowable capital debt and interest costs. If the new nursing facility has decreased its licensed capacity, the aggregate investment per bed limit in subdivision 3a, paragraph (c), shall apply. If the new nursing facility has retained a portion of the original physical plant for nursing facility usage, then a portion of the appraised value prior to the replacement must be retained and included in the calculation of the incremental change in the nursing facility's rental per diem. For purposes of this part, the original nursing facility means the nursing facility prior to the total replacement project. The portion of the appraised value to be retained shall be calculated according to clauses (1) to (3):

(1) The numerator of the allocation ratio shall be the square footage of the area in the original physical plant which is being retained for nursing facility usage.

(2) The denominator of the allocation ratio shall be the total square footage of the original nursing facility physical plant.

(3) Each component of the nursing facility's allowable appraised value prior to the total replacement project shall be multiplied by the allocation ratio developed by dividing clause (1) by clause (2).

In the case of either type of total replacement as authorized under section 144A.071 or 144A.073, the provisions of this subdivision shall also apply. For purposes of the moratorium exception authorized under section 144A.071, subdivision 4a, paragraph (s), if the total replacement involves the renovation and use of an existing health care facility physical plant, the new allowable capital asset costs and related debt and interest costs shall include first the allowable capital asset costs and related debt and interest costs of the renovation, to which shall be added the allowable capital asset costs of the existing physical plant prior to the renovation, and if reported by the facility, the related allowable capital debt and interest costs.

(g) Notwithstanding Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), for a total replacement, as defined in paragraph (f), authorized under section

144A.071 or 144A.073 after July 1, 1999, or any building project that is a relocation, renovation, upgrading, or conversion completed on or after July 1, 2001, the replacement-costs-new per bed limit shall be $74,280 per licensed bed in multiple-bed rooms, $92,850 per licensed bed in semiprivate rooms with a fixed partition separating the resident beds, and $111,420 per licensed bed in single rooms. Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), does not apply. These amounts must be adjusted annually as specified in subdivision 3f, paragraph (a), beginning January 1, 2000.

(h) For a total replacement, as defined in paragraph (f), authorized under section 144A.073 for a 96-bed nursing home in Carlton county, the replacement-costs-new per bed limit shall be $74,280 per licensed bed in multiple-bed rooms, $92,850 per licensed bed in semiprivate rooms with a fixed partition separating the resident's beds, and $111,420 per licensed bed in a single room. Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), does not apply. The resulting maximum allowable replacement-costs-new multiplied by 1.25 shall constitute the project's dollar threshold for purposes of application of the limit set forth in section 144A.071, subdivision 2. The commissioner of health may waive the requirements of section 144A.073, subdivision 3b, paragraph (b), clause (2), on the condition that the other requirements of that paragraph are met.

(i) For a renovation authorized under section 144A.073 for a 65-bed nursing home in St. Louis county, the incremental increase in rental rate for purposes of paragraph (d) shall be $8.16, and the total replacement cost, allowable appraised value, allowable debt, and allowable interest shall be increased according to the incremental increase.

(j) For a total replacement, as defined in paragraph (f), authorized under section 144A.073 involving a new building addition that relocates beds from three-bed wards for an 80-bed nursing home in Redwood county, the replacement-costs-new per bed limit shall be $74,280 per licensed bed for multiple-bed rooms; $92,850 per licensed bed for semiprivate rooms with a fixed partition separating the beds; and $111,420 per licensed bed for single rooms. These amounts shall be adjusted annually, beginning January 1, 2001. Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), does not apply. The resulting maximum allowable replacement-costs-new multiplied by 1.25 shall constitute the project's dollar threshold for purposes of application of the limit set forth in section 144A.071, subdivision 2. The commissioner of health may waive the requirements of section 144A.073, subdivision 3b, paragraph (b), clause (2), on the condition that the other requirements of that paragraph are met.

[For text of subds 18 to 30, see M.S.2000]

Subd. 31. **Nursing facility rate increases beginning July 1, 2001, and July 1, 2002.** For the rate years beginning July 1, 2001, and July 1, 2002, the commissioner shall provide to each nursing facility reimbursed under this section or section 256B.434 an adjustment equal to 3.0 percent of the total operating payment rate. The operating payment rates in effect on June 30, 2001, shall include the adjustment in subdivision 2i, paragraph (c).

Subd. 32. **Payment during first 90 days.** (a) For rate years beginning on or after July 1, 2001, the total payment rate for a facility reimbursed under this section, section 256B.434, or any other section for the first 90 paid days after admission shall be:

(1) for the first 30 paid days, the rate shall be 120 percent of the facility's medical assistance rate for each case mix class; and

(2) for the next 60 paid days after the first 30 paid days, the rate shall be 110 percent of the facility's medical assistance rate for each case mix class.

(b) Beginning with the 91st paid day after admission, the payment rate shall be the rate otherwise determined under this section, section 256B.434, or any other section.

(c) This subdivision applies to admissions occurring on or after July 1, 2001.

Subd. 33. **Staged reduction in rate disparities.** (a) For the rate years beginning July 1, 2001, and July 1, 2002, the commissioner shall adjust the operating payment rates for low-rate nursing facilities reimbursed under this section or section 256B.434.

(b) For the rate year beginning July 1, 2001, for each case mix level, if the amount computed under subdivision 32 is less than the amount in clause (1), the commissioner shall make available the lesser of the amount in clause (1) or an increase of ten percent over the rate in effect on June 30, 2001, as an adjustment to the operating payment rate. For the rate year beginning July 1, 2002, for each case mix level, if the amount computed under subdivision 32 is less than the amount in clause (2), the commissioner shall make available the lesser of the amount in clause (2) or an increase of ten percent over the rate in effect on June 30, 2002, as an adjustment to the operating payment rate. For purposes of this subdivision, nursing facilities shall be considered to be metro if they are located in Anoka, Carver, Dakota, Hennepin, Olmsted, Ramsey, Scott, or Washington counties; or in the cities of Moorhead or Breckenridge; or in St. Louis county, north of Toivola and south of Cook; or in Itasca county, east of a north south line two miles west of Grand Rapids:

(1) Operating Payment Rate Target Level for July 1, 2001:

Case Mix Classification	Metro	Nonmetro
A	$ 76.00	$ 68.13
B	$ 83.40	$ 74.46
C	$ 91.67	$ 81.63
D	$ 99.51	$ 88.04
E	$107.46	$ 94.87
F	$107.96	$ 95.29
G	$114.67	$100.98
H	$126.99	$111.31
I	$131.42	$115.06
J	$138.34	$120.85
K	$152.26	$133.10

(2) Operating Payment Rate Target Level for July 1, 2002:

Case Mix Classification	Metro	Nonmetro
A	$ 78.28	$ 70.51
B	$ 85.91	$ 77.16
C	$ 94.42	$ 84.62
D	$102.50	$ 91.42
E	$110.68	$ 98.40
F	$111.20	$ 98.84
G	$118.11	$104.77
H	$130.80	$115.64
I	$135.38	$119.50
J	$142.49	$125.38
K	$156.85	$137.77

Subd. 34. **Nursing facility rate increases beginning July 1, 2001, and July 1, 2002.** (a) For the rate years beginning July 1, 2001, and July 1, 2002, two-thirds of the money resulting from the rate adjustment under subdivision 31 and one-half of the money resulting from the rate adjustment under subdivisions 32 and 33 must be used to increase the wages and benefits and pay associated costs of all employees except management fees, the administrator, and central office staff.

(b) Money received by a facility as a result of the rate adjustments provided in subdivisions 31 to 33, which must be used as provided in paragraph (a), must be used only for wage and benefit increases implemented on or after July 1, 2001, or July 1, 2002, respectively, and must not be used for wage increases implemented prior to those dates.

(c) Nursing facilities may apply for the portions of the rate adjustments under subdivisions 31 to 33, which must be used as provided in paragraph (a). The application

must be made to the commissioner and contain a plan by which the nursing facility will distribute to employees of the nursing facility the funds, which must be used as provided in paragraph (a). For nursing facilities in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes the plan. A negotiated agreement may constitute the plan only if the agreement is finalized after the date of enactment of all increases for the rate year. The commissioner shall review the plan to ensure that the rate adjustments are used as provided in paragraph (a). To be eligible, a facility must submit its plan for the wage and benefit distribution by December 31 each year. If a facility's plan for wage and benefit distribution is effective for its employees after July 1 of the year that the funds are available, the portion of the rate adjustments, which must be used as provided in paragraph (a), are effective the same date as its plan.

(d) A hospital-attached nursing facility may include costs in their distribution plan for wages and benefits and associated costs of employees in the organization's shared services departments, provided that:

(1) the nursing facility and the hospital share common ownership; and

(2) adjustments for hospital services using the diagnostic-related grouping payment rates per admission under Medicare are less than three percent during the 12 months prior to the effective date of these rate adjustments.

If a hospital-attached facility meets the qualifications in this paragraph, the difference between the rate adjustments approved for nursing facility services and the rate increase approved for hospital services may be permitted as a distribution in the hospital-attached facility's plan regardless of whether the use of those funds is shown as being attributable to employee hours worked in the nursing facility or employee hours worked in the hospital.

For the purposes of this paragraph, a hospital-attached nursing facility is one that meets the definition under subdivision 2j, or, in the case of a facility reimbursed under section 256B.434, met this definition at the time their last payment rate was established under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section.

(e) A copy of the approved distribution plan must be made available to all employees by giving each employee a copy or by posting it in an area of the nursing facility to which all employees have access. If an employee does not receive the wage and benefit adjustment described in the facility's approved plan and is unable to resolve the problem with the facility's management or through the employee's union representative, the employee may contact the commissioner at an address or telephone number provided by the commissioner and included in the approved plan.

(f) Notwithstanding section 256B.48, subdivision 1, clause (a), upon the request of a nursing facility, the commissioner may authorize the facility to raise per diem rates for private-pay residents on July 1 by the amount anticipated to be required upon implementation of the rate adjustments allowable under subdivisions 31 to 33. The commissioner shall require any amounts collected under this paragraph, which must be used as provided in paragraph (a), to be placed in an escrow account established for this purpose with a financial institution that provides deposit insurance until the medical assistance rate is finalized. The commissioner shall conduct audits as necessary to ensure that:

(1) the amounts collected are retained in escrow until medical assistance rates are increased to reflect the wage-related adjustment; and

(2) any amounts collected from private-pay residents in excess of the final medical assistance rate are repaid to the private-pay residents with interest at the rate used by the commissioner of revenue for the late payment of taxes and in effect on the date the distribution plan is approved by the commissioner of human services.

Subd. 35. **Exclusion of raw food cost adjustment.** For rate years beginning on or after July 1, 2001, in calculating a nursing facility's operating cost per diem for the purposes of constructing an array, determining a median, or otherwise performing a statistical measure of nursing facility payment rates to be used to determine future rate

increases under this section, section 256B.434, or any other section, the commissioner shall exclude adjustments for raw food costs under subdivision 2b, paragraph (h), that are related to providing special diets based on religious beliefs.

Subd. 36. **Employee scholarship costs and training in English as a second language.** (a) For the period between July 1, 2001, and June 30, 2003, the commissioner shall provide to each nursing facility reimbursed under this section, section 256B.434, or any other section, a scholarship per diem of 25 cents to the total operating payment rate to be used:

(1) for employee scholarships that satisfy the following requirements:

(i) scholarships are available to all employees who work an average of at least 20 hours per week at the facility except the administrator, department supervisors, and registered nurses; and

(ii) the course of study is expected to lead to career advancement with the facility or in long-term care, including medical care interpreter services and social work; and

(2) to provide job-related training in English as a second language.

(b) A facility receiving a rate adjustment under this subdivision may submit to the commissioner on a schedule determined by the commissioner and on a form supplied by the commissioner a calculation of the scholarship per diem, including: the amount received from this rate adjustment; the amount used for training in English as a second language; the number of persons receiving the training; the name of the person or entity providing the training; and for each scholarship recipient, the name of the recipient, the amount awarded, the educational institution attended, the nature of the educational program, the program completion date, and a determination of the per diem amount of these costs based on actual resident days.

(c) On July 1, 2003, the commissioner shall remove the 25 cent scholarship per diem from the total operating payment rate of each facility.

(d) For rate years beginning after June 30, 2003, the commissioner shall provide to each facility the scholarship per diem determined in paragraph (b).

History: *1Sp2001 c 9 art 5 s 15-21; art 6 s 6*

256B.433 ANCILLARY SERVICES.

[For text of subds 1 to 3, see M.S.2000]

Subd. 3a. **Exemption from requirement for separate therapy billing.** The provisions of subdivision 3 do not apply to nursing facilities that are reimbursed according to the provisions of section 256B.431. Nursing facilities that are reimbursed according to the provisions of section 256B.434 and are located in a county participating in the prepaid medical assistance program are exempt from the maximum therapy rent revenue provisions of subdivision 3, paragraph (c).

History: *1Sp2001 c 9 art 5 s 22*

256B.434 CONTRACTUAL ALTERNATIVE PAYMENT DEMONSTRATION PROJECT FOR NURSING HOMES.

[For text of subds 1 to 3, see M.S.2000]

Subd. 4. **Alternate rates for nursing facilities.** (a) For nursing facilities which have their payment rates determined under this section rather than section 256B.431, the commissioner shall establish a rate under this subdivision. The nursing facility must enter into a written contract with the commissioner.

(b) A nursing facility's case mix payment rate for the first rate year of a facility's contract under this section is the payment rate the facility would have received under section 256B.431.

(c) A nursing facility's case mix payment rates for the second and subsequent years of a facility's contract under this section are the previous rate year's contract payment rates plus an inflation adjustment and, for facilities reimbursed under this section or

section 256B.431, an adjustment to include the cost of any increase in health department licensing fees for the facility taking effect on or after July 1, 2001. The index for the inflation adjustment must be based on the change in the Consumer Price Index-All Items (United States City average) (CPI-U) forecasted by Data Resources, Inc., as forecasted in the fourth quarter of the calendar year preceding the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined. For the rate years beginning on July 1, 1999, July 1, 2000, July 1, 2001, and July 1, 2002, this paragraph shall apply only to the property-related payment rate, except that adjustments to include the cost of any increase in health department licensing fees taking effect on or after July 1, 2001, shall be provided. In determining the amount of the property-related payment rate adjustment under this paragraph, the commissioner shall determine the proportion of the facility's rates that are property-related based on the facility's most recent cost report.

(d) The commissioner shall develop additional incentive-based payments of up to five percent above the standard contract rate for achieving outcomes specified in each contract. The specified facility-specific outcomes must be measurable and approved by the commissioner. The commissioner may establish, for each contract, various levels of achievement within an outcome. After the outcomes have been specified the commissioner shall assign various levels of payment associated with achieving the outcome. Any incentive-based payment cancels if there is a termination of the contract. In establishing the specified outcomes and related criteria the commissioner shall consider the following state policy objectives:

(1) improved cost effectiveness and quality of life as measured by improved clinical outcomes;

(2) successful diversion or discharge to community alternatives;

(3) decreased acute care costs;

(4) improved consumer satisfaction;

(5) the achievement of quality; or

(6) any additional outcomes proposed by a nursing facility that the commissioner finds desirable.

[For text of subds 4a and 4b, see M.S.2000]

Subd. 4c. **Facility rate increases effective January 1, 2002.** For the rate period beginning January 1, 2002, and for the rate year beginning July 1, 2002, a nursing facility in Morrison county licensed for 83 beds as of March 1, 2001, shall receive an increase of $2.54 in each case mix payment rate to offset property tax payments due as a result of the facility's conversion from nonprofit to for-profit status. The increase under this subdivision shall be added following the determination under this chapter of the payment rate for the rate year beginning July 1, 2001, and shall be included in the facility's total payment rates for the purposes of determining future rates under this section or any other section.

Subd. 4d. **Facility rate increases effective July 1, 2001.** For the rate year beginning July 1, 2001, a nursing facility in Hennepin county licensed for 302 beds shall receive an increase of 29 cents in each case mix payment rate to correct an error in the cost-reporting system that occurred prior to the date that the facility entered the alternative payment demonstration project. The increase under this subdivision shall be added following the determination under this chapter of the payment rate for the rate year beginning July 1, 2001, and shall be included in the facility's total payment rates for the purposes of determining future rates under this section or any other section.

Subd. 4e. **Rate increase effective July 1, 2001.** A nursing facility in Anoka county licensed for 98 beds as of July 1, 2000, shall receive a total increase of $10 in each case mix rate for the rate year beginning July 1, 2001, as a result of increases provided under this subdivision and section 256B.431, subdivision 33. The increases under this subdivision shall be added prior to the determination under section 256B.431, subdivision 33, of the payment rate for the rate year beginning July 1, 2001, and shall be included in

the facility's total payment rate for purposes of determining future rates under this section or any other section through June 30, 2004.

Subd. 5. [Repealed, 1Sp2001 c 9 art 5 s 41]

[For text of subds 6 to 12, see M.S.2000]

Subd. 13. [Repealed, 2001 c 161 s 58]

[For text of subds 14 to 16, see M.S.2000]

History: *1Sp2001 c 9 art 5 s 23-26*

256B.436 VOLUNTARY CLOSURES; PLANNING.

Subdivision 1. **Definitions.** (a) "Closure" means the voluntary cessation of operations of a nursing facility and voluntary delicensure and decertification of all nursing facility beds of the nursing facility.

(b) "Commencement of closure" means the date on which the commissioner of health is notified of a planned closure in accordance with an approved closure plan.

(c) "Completion of closure" means the date on which the final resident of the nursing facility or nursing facilities designated for closure in an approved closure plan is discharged from the facility or facilities.

(d) "Closure plan" means a plan to close one or more nursing facilities and reallocate the resulting savings to provide special rate adjustments at other facilities.

(e) "Interim closure payments" means the medical assistance payments that may be made to a nursing facility designated for closure in an approved plan under this section.

(f) "Phased plan" means a closure plan affecting more than one nursing facility undergoing closure that is commenced and completed in phases.

(g) "Special rate adjustment" means an increase in a nursing facility's operating rates under this section.

(h) "Standardized resident days" means the standardized resident days as calculated under Minnesota Rules, part 9549.0054, subpart 2, based on the resident days in each resident class for the most recent reporting period required to be reported to the commissioner.

Subd. 2. **Proposal for a closure plan.** (a) One or more nursing facilities that are owned or operated by a nonprofit corporation owning or operating more than 22 nursing facilities licensed in the state of Minnesota may submit to the commissioner a proposal for a closure plan under this section. Between February 25, 2000, and June 30, 2001, the commissioner may negotiate phased plans for closure of up to seven nursing facilities.

(b) A facility or facilities reimbursed under section 256B.431 or 256B.434 with a closure plan approved by the commissioner under subdivision 4 are eligible for the following payments:

(1) facilities designated for closure are eligible for interim closure payments under subdivision 5; and

(2) facilities that remain open are eligible for a special rate adjustment.

(c) To be considered for approval, a proposal must include the following:

(1) a description of the proposed closure plan, which shall include identification of the facility or facilities to receive a special rate adjustment, the amount and timing of a special rate adjustment proposed for each facility for the case mix level "A" operating rate, the standardized resident days for each facility for which a special rate adjustment is proposed, and the effective date for each special rate adjustment. The actual special rate adjustment for a facility shall be allocated proportionately to the various rate per diems included in that facility's operating rate;

(2) an analysis of the projected state medical assistance costs of the closure plan as proposed, including the estimated costs of the special rate adjustments and estimated resident relocation costs, including county government costs;

(3) an analysis of the projected state medical assistance savings of the closure plan as proposed, including any savings projected to result from closure of one or more nursing facilities;

(4) the proposed timetable for any proposed closure, including the proposed dates for commencement and completion of closure;

(5) the proposed relocation plan for current residents of any facility designated for closure. The proposed relocation plan must be designed to comply with all applicable state and federal statutes and regulations, including, but not limited to, Minnesota Rules, parts 4655.6810 to 4655.6830; parts 4658.1600 to 4658.1690; and parts 9546.0010 to 9546.0060; and

(6) documentation, in a format approved by the commissioner, that all the nursing facilities receiving a special rate adjustment under the plan have accepted joint and several liability for recovery of overpayments under section 256B.0641, subdivision 2, for the facilities designated for closure under the plan.

[For text of subd 3, see M.S.2000]

Subd. 4. **Review and approval of proposals.** (a) The commissioner may grant interim closure payments or special rate adjustments for a nursing facility or facilities according to an approved plan that satisfies the requirements of this section. The commissioner shall not approve a proposal unless the commissioner determines that projected state savings of the plan equal or exceed projected state and county government costs, including facility costs during the closure period, the estimated costs of special rate adjustments, estimated resident relocation costs, the cost of services to relocated residents, and state agency administrative costs directly related to the accomplishment of duties specified in this subdivision relative to that proposal. To achieve cost neutrality costs may only be offset against savings that occur within the same fiscal year. For purposes of a phased plan, the requirement that costs must not exceed savings applies to both the aggregate costs and savings of the plan and to each phase of the plan. A special rate adjustment under this section shall be effective no earlier than the first day of the month following completion of closure of all facilities designated for closure under the plan. For purposes of a phased plan, the special rate adjustment for each phase shall be effective no earlier than the first day of the month following completion of closure of all facilities designated for closure in that phase of the plan. No special rate adjustment under this section shall take effect prior to July 1, 2000.

(b) Upon receipt of a proposal for a closure plan, the commissioner shall provide a copy of the proposal to the commissioner of health. The commissioner of health shall certify to the commissioner within 30 days whether the proposal, if implemented, will satisfy the requirements of Minnesota Rules, parts 4655.6810 to 4655.6830, and parts 4658.1600 to 4658.1690. The commissioner shall not approve a plan under this section unless the commissioner of health has made the certification required under this paragraph.

(c) The commissioner shall review a proposal for a closure plan to determine whether it satisfies the requirements of this section. A determination shall be made within 60 days of the date the proposal is submitted. If the commissioner determines that the proposal does not satisfy the requirements of this section, or if the commissioner of health does not certify the proposal under paragraph (b), the applicant shall be provided written notice as soon as practicable specifying the deficiencies of the proposal. The proposal may be modified and resubmitted for further review by each commissioner. The commissioner of health shall review a modified proposal within 30 days from the date it is submitted, and the commissioner shall make a final determination on whether the proposal satisfies the requirements of this section within 60 days of the date the modified proposal is submitted.

(d) Approval of a closure plan expires 18 months after approval by the commissioner, unless commencement of closure has occurred at all facilities designated for closure under the plan.

[For text of subd 5, see M.S.2000]

Subd. 6. **Cost savings of closure.** For purposes of this section, the calculation of medical assistance cost savings from the closure of a nursing facility designated for closure under a closure plan shall be according to the following criteria:

(a) The projected medical assistance savings of the closure of a facility shall be the aggregate medical assistance payments to the facility for the most recently completed state fiscal year prior to submission of the proposal, as reflected in the number of resident days of care for each resident class provided by the facility in that fiscal year, multiplied by the payment rate for each resident class.

(b) If one or more facilities designated for closure in an approved closure plan are not able to be closed for any reason, or projection of savings for that closure are otherwise prohibited under this section, the projected medical assistance savings from that closure may not be offset against the medical assistance costs of special rate adjustments under the plan. In that event, the applicant must notify the commissioner in writing and the applicant must either amend its proposal by reducing the special rate adjustment to reduce the medical assistance cost of the plan by at least the amount of the medical assistance savings that were projected from the closure of that facility or withdraw the plan.

(c) No medical assistance savings shall be projected from closure of a nursing facility that is designated for closure under a closure plan, if the facility is:

(1) subject to adverse licensure action under section 144A.11; or

(2) located in a county with a ratio of nursing facility beds to county residents age 85 and over that is in the lowest quartile of all counties in the state, at the time the proposal is submitted or at the commencement of closure.

(d) Medical assistance savings under paragraph (a) shall be recognized for purposes of this section beginning the first day of the month following the month of completion of closure for all facilities designated for closure under the plan, or all facilities designated for closure under that phase for a phased plan.

[For text of subds 7 and 8, see M.S.2000]

History: *2001 c 36 s 1; 1Sp2001 c 9 art 5 s 40*

256B.437 NURSING FACILITY VOLUNTARY CLOSURES; PLANNING AND DEVELOPMENT OF COMMUNITY-BASED ALTERNATIVES.

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to subdivisions 2 to 8.

(b) "Closure" means the cessation of operations of a nursing facility and delicensure and decertification of all beds within the facility.

(c) "Closure plan" means a plan to close a nursing facility and reallocate a portion of the resulting savings to provide planned closure rate adjustments at other facilities.

(d) "Commencement of closure" means the date on which residents and designated representatives are notified of a planned closure as provided in section 144A.161, subdivision 5a, as part of an approved closure plan.

(e) "Completion of closure" means the date on which the final resident of the nursing facility designated for closure in an approved closure plan is discharged from the facility.

(f) "Partial closure" means the delicensure and decertification of a portion of the beds within the facility.

(g) "Planned closure rate adjustment" means an increase in a nursing facility's operating rates resulting from a planned closure or a planned partial closure of another facility.

Subd. 2. **Planning and development of community-based services.** (a) The commissioner of human services shall establish a process to adjust the capacity and distribution of long-term care services to equalize the supply and demand for different types of services. This process must include community planning, expansion or establishment of needed services, and analysis of voluntary nursing facility closures.

(b) The purpose of this process is to support the planning and development of community-based services. This process must support early intervention, advocacy, and consumer protection while providing resources and incentives for expanded county planning and for nursing facilities to transition to meet community needs.

(c) The process shall support and facilitate expansion of community-based services under the county-administered alternative care program under section 256B.0913 and waivers for elderly under section 256B.0915, including, but not limited to, the development of supportive services such as housing and transportation. The process shall utilize community assessments and planning developed for the community health services plan and plan update and for the community social services act plan, and other relevant information.

(d) The commissioners of health and human services, as appropriate, shall provide, by July 15, 2001, available data necessary for the county, including, but not limited to, data on nursing facility bed distribution, housing with services options, the closure of nursing facilities that occur outside of the planned closure process, and approval of planned closures in the county and contiguous counties.

(e) Each county shall submit to the commissioner of human services, by October 15, 2001, a gaps analysis that identifies local service needs, pending development of services, and any other issues that would contribute to or impede further development of community-based services. The gaps analysis must also be sent to the local area agency on aging and, if applicable, local SAIL projects, for review and comment. The review and comment must assess needs across county boundaries. The area agencies on aging and SAIL projects must provide the commissioner and the counties with their review and analyses by November 15, 2001.

(f) The addendum to the biennial plan shall be submitted annually, beginning December 31, 2001, and each December 31 thereafter, and shall include recommendations for development of community-based services. Both planning and implementation shall be implemented within the amount of funding made available to the county board for these purposes.

(g) The plan, within the funding allocated, shall:

(1) include the gaps analysis required by paragraph (e);

(2) involve providers, consumers, cities, townships, businesses, and area agencies on aging in the planning process;

(3) address the availability of alternative care and elderly waiver services for eligible recipients;

(4) address the development of other supportive services, such as transit, housing, and workforce and economic development; and

(5) estimate the cost and timelines for development.

(h) The biennial plan addendum shall be coordinated with the county mental health plan for inclusion in the community health services plan and included as an addendum to the community social services plan.

(i) The county board having financial responsibility for persons present in another county shall cooperate with that county for planning and development of services.

(j) The county board shall cooperate in planning and development of community-based services with other counties, as necessary, and coordinate planning for long-term care services that involve more than one county, within the funding allocated for these purposes.

(k) The commissioners of health and human services, in cooperation with county boards, shall report to the legislature by February 1 of each year, beginning February 1, 2002, regarding the development of community-based services, transition or closure of

nursing facilities, and specific gaps in services in identified geographic areas that may require additional resources or flexibility, as documented by the process in this subdivision and reported to the commissioners by December 31 of each year.

Subd. 3. **Applications for planned closure of nursing facilities.** (a) By August 15, 2001, the commissioner of human services shall implement and announce a program for closure or partial closure of nursing facilities. Names and identifying information provided in response to the announcement shall remain private unless approved, according to the timelines established in the plan. The announcement must specify:

(1) the criteria in subdivision 4 that will be used by the commissioner to approve or reject applications;

(2) a requirement for the submission of a letter of intent before the submission of an application;

(3) the information that must accompany an application; and

(4) that applications may combine planned closure rate adjustments with moratorium exception funding, in which case a single application may serve both purposes.

Between August 1, 2001, and June 30, 2003, the commissioner may approve planned closures of up to 5,140 nursing facility beds, less the number of licensed beds in facilities that close during the same time period without approved closure plans or that have notified the commissioner of health of their intent to close without an approved closure plan.

(b) A facility or facilities reimbursed under section 256B.431 or 256B.434 with a closure plan approved by the commissioner under subdivision 5 may assign a planned closure rate adjustment to another facility or facilities that are not closing or in the case of a partial closure, to the facility undertaking the partial closure. A facility may also elect to have a planned closure rate adjustment shared equally by the five nursing facilities with the lowest total operating payment rates in the state development region designated under section 462.385, in which the facility that is closing is located. The planned closure rate adjustment must be calculated under subdivision 6. Facilities that close without a closure plan, or whose closure plan is not approved by the commissioner, are not eligible to assign a planned closure rate adjustment under subdivision 6. The commissioner shall calculate the amount the facility would have been eligible to assign under subdivision 6, and shall use this amount to provide equal rate adjustments to the five nursing facilities with the lowest total operating payment rates in the state development region designated under section 462.385, in which the facility that closed is located.

(c) To be considered for approval, an application must include:

(1) a description of the proposed closure plan, which must include identification of the facility or facilities to receive a planned closure rate adjustment and the amount and timing of a planned closure rate adjustment proposed for each facility;

(2) the proposed timetable for any proposed closure, including the proposed dates for announcement to residents, commencement of closure, and completion of closure;

(3) the proposed relocation plan for current residents of any facility designated for closure. The proposed relocation plan must be designed to comply with all applicable state and federal statutes and regulations, including, but not limited to, section 144A.161;

(4) a description of the relationship between the nursing facility that is proposed for closure and the nursing facility or facilities proposed to receive the planned closure rate adjustment. If these facilities are not under common ownership, copies of any contracts, purchase agreements, or other documents establishing a relationship or proposed relationship must be provided;

(5) documentation, in a format approved by the commissioner, that all the nursing facilities receiving a planned closure rate adjustment under the plan have accepted joint and several liability for recovery of overpayments under section 256B.0641, subdivision 2, for the facilities designated for closure under the plan; and

(6) an explanation of how the application coordinates with planning efforts under subdivision 2. If the planning group does not support a level of nursing facility closures that the commissioner considers to be reasonable, the commissioner may approve a planned closure proposal without its support.

(d) The application must address the criteria listed in subdivision 4.

Subd. 4. **Criteria for review of application.** In reviewing and approving closure proposals, the commissioner shall consider, but not be limited to, the following criteria:

(1) improved quality of care and quality of life for consumers;

(2) closure of a nursing facility that has a poor physical plant, which may be evidenced by the conditions referred to in section 144A.073, subdivision 4, clauses (4) and (5);

(3) the existence of excess nursing facility beds, measured in terms of beds per thousand persons aged 85 or older. The excess must be measured in reference to:

(i) the county in which the facility is located;

(ii) the county and all contiguous counties;

(iii) the region in which the facility is located; or

(iv) the facility's service area;

the facility shall indicate in its application the service area it believes is appropriate for this measurement. A facility in a county that is in the lowest quartile of counties with reference to beds per thousand persons aged 85 or older is not in an area of excess capacity;

(4) low-occupancy rates, provided that the unoccupied beds are not the result of a personnel shortage. In analyzing occupancy rates, the commissioner shall examine waiting lists in the applicant facility and at facilities in the surrounding area, as determined under clause (3);

(5) evidence of coordination between the community planning process and the facility application. If the planning group does not support a level of nursing facility closures that the commissioner considers to be reasonable, the commissioner may approve a planned closure proposal without its support;

(6) proposed usage of funds available from a planned closure rate adjustment for care-related purposes;

(7) innovative use planned for the closed facility's physical plant;

(8) evidence that the proposal serves the interests of the state; and

(9) evidence of other factors that affect the viability of the facility, including excessive nursing pool costs.

Subd. 5. **Review and approval of applications.** (a) The commissioner of human services, in consultation with the commissioner of health, shall approve or disapprove an application within 30 days after receiving it. The commissioner may appoint an advisory review panel composed of representatives of counties, SAIL projects, consumers, and providers to review proposals and provide comments and recommendations to the committee. The commissioners of human services and health shall provide staff and technical assistance to the committee for the review and analysis of proposals.

(b) Approval of a planned closure expires 18 months after approval by the commissioner of human services, unless commencement of closure has begun.

(c) The commissioner of human services may change any provision of the application to which the applicant, the regional planning group, and the commissioner agree.

Subd. 6. **Planned closure rate adjustment.** (a) The commissioner of human services shall calculate the amount of the planned closure rate adjustment available under subdivision 3, paragraph (b), for up to 5,140 beds according to clauses (1) to (4):

(1) the amount available is the net reduction of nursing facility beds multiplied by $2,080;

(2) the total number of beds in the nursing facility or facilities receiving the planned closure rate adjustment must be identified;

(3) capacity days are determined by multiplying the number determined under clause (2) by 365; and

(4) the planned closure rate adjustment is the amount available in clause (1), divided by capacity days determined under clause (3).

(b) A planned closure rate adjustment under this section is effective on the first day of the month following completion of closure of the facility designated for closure in the application and becomes part of the nursing facility's total operating payment rate.

(c) Applicants may use the planned closure rate adjustment to allow for a property payment for a new nursing facility or an addition to an existing nursing facility or as an operating payment rate adjustment. Applications approved under this subdivision are exempt from other requirements for moratorium exceptions under section 144A.073, subdivisions 2 and 3.

(d) Upon the request of a closing facility, the commissioner must allow the facility a closure rate adjustment as provided under section 144A.161, subdivision 10.

Subd. 7. **Other rate adjustments.** Facilities receiving planned closure rate adjustments remain eligible for any applicable rate adjustments provided under section 256B.431, 256B.434, or any other section.

Subd. 8. **County costs.** The commissioner of human services shall allocate funds for relocation costs incurred by counties for planned closures under this section as provided under section 144A.161, subdivision 11.

History: *1Sp2001 c 9 art 5 s 27*

256B.438 IMPLEMENTATION OF A CASE MIX SYSTEM FOR NURSING FACILITIES BASED ON THE MINIMUM DATA SET.

Subdivision 1. **Scope.** This section establishes the method and criteria used to determine resident reimbursement classifications based upon the assessments of residents of nursing homes and boarding care homes whose payment rates are established under section 256B.431, 256B.434, or 256B.435. Resident reimbursement classifications shall be established according to the 34 group, resource utilization groups, version III or RUG-III model as described in section 144.0724. Reimbursement classifications established under this section shall be implemented after June 30, 2002, but no later than January 1, 2003.

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given.

(a) **Assessment reference date.** "Assessment reference date" has the meaning given in section 144.0724, subdivision 2, paragraph (a).

(b) **Case mix index.** "Case mix index" has the meaning given in section 144.0724, subdivision 2, paragraph (b).

(c) **Index maximization.** "Index maximization" has the meaning given in section 144.0724, subdivision 2, paragraph (c).

(d) **Minimum data set.** "Minimum data set" has the meaning given in section 144.0724, subdivision 2, paragraph (d).

(e) **Representative.** "Representative" has the meaning given in section 144.0724, subdivision 2, paragraph (e).

(f) **Resource utilization groups or rug.** "Resource utilization groups" or "RUG" has the meaning given in section 144.0724, subdivision 2, paragraph (f).

Subd. 3. **Case mix indices.** (a) The commissioner of human services shall assign a case mix index to each resident class based on the Health Care Financing Administration's staff time measurement study and adjusted for Minnesota-specific wage indices. The case mix indices assigned to each resident class shall be published in the

Minnesota State Register at least 120 days prior to the implementation of the 34 group, RUG-III resident classification system.

(b) An index maximization approach shall be used to classify residents.

(c) After implementation of the revised case mix system, the commissioner of human services may annually rebase case mix indices and base rates using more current data on average wage rates and staff time measurement studies. This rebasing shall be calculated under subdivision 7, paragraph (b). The commissioner shall publish in the Minnesota State Register adjusted case mix indices at least 45 days prior to the effective date of the adjusted case mix indices.

Subd. 4. **Resident assessment schedule.** (a) Nursing facilities shall conduct and submit case mix assessments according to the schedule established by the commissioner of health under section 144.0724, subdivisions 4 and 5.

(b) The resident reimbursement classifications established under section 144.0724, subdivision 3, shall be effective the day of admission for new admission assessments. The effective date for significant change assessments shall be the assessment reference date. The effective date for annual and second quarterly assessments shall be the first day of the month following assessment reference date.

Subd. 5. **Notice of resident reimbursement classification.** Nursing facilities shall provide notice to a resident of the resident's case mix classification according to procedures established by the commissioner of health under section 144.0724, subdivision 7.

Subd. 6. **Reconsideration of resident classification.** Any request for reconsideration of a resident classification must be made under section 144.0724, subdivision 8.

Subd. 7. **Rate determination upon transition to RUG-III payment rates.** (a) The commissioner of human services shall determine payment rates at the time of transition to the RUG based payment model in a facility-specific, budget-neutral manner. The case mix indices as defined in subdivision 3 shall be used to allocate the case mix adjusted component of total payment across all case mix groups. To transition from the current calculation methodology to the RUG based methodology, the commissioner of health shall report to the commissioner of human services the resident days classified according to the categories defined in subdivision 3 for the 12-month reporting period ending September 30, 2001, for each nursing facility. The commissioner of human services shall use this data to compute the standardized days for the reporting period under the RUG system.

(b) The commissioner of human services shall determine the case mix adjusted component of the rate as follows:

(1) determine the case mix portion of the 11 case mix rates in effect on June 30, 2002, or the 34 case mix rates in effect on or after June 30, 2003;

(2) multiply each amount in clause (1) by the number of resident days assigned to each group for the reporting period ending September 30, 2001, or the most recent year for which data is available;

(3) compute the sum of the amounts in clause (2);

(4) determine the total RUG standardized days for the reporting period ending September 30, 2001, or the most recent year for which data is available using the new indices calculated under subdivision 3, paragraph (c);

(5) divide the amount in clause (3) by the amount in clause (4) which shall be the average case mix adjusted component of the rate under the RUG method; and

(6) multiply this average rate by the case mix weight in subdivision 3 for each RUG group.

(c) The noncase mix component will be allocated to each RUG group as a constant amount to determine the transition payment rate. Any other rate adjustments that are effective on or after July 1, 2002, shall be applied to the transition rates determined under this section.

History: *1Sp2001 c 9 art 5 s 28*

256B.439 LONG-TERM CARE QUALITY PROFILES.

Subdivision 1. **Development and implementation of quality profiles.** (a) The commissioner of human services, in cooperation with the commissioner of health, shall develop and implement a quality profile system for nursing facilities and, beginning not later than July 1, 2003, other providers of long-term care services, except when the quality profile system would duplicate requirements under section 256B.5011, 256B.5012, or 256B.5013. The system must be developed and implemented to the extent possible without the collection of significant amounts of new data. To the extent possible, the system must incorporate or be coordinated with information on quality maintained by area agencies on aging, long-term care trade associations, and other entities. The system must be designed to provide information on quality to:

(1) consumers and their families to facilitate informed choices of service providers;

(2) providers to enable them to measure the results of their quality improvement efforts and compare quality achievements with other service providers; and

(3) public and private purchasers of long-term care services to enable them to purchase high-quality care.

(b) The system must be developed in consultation with the long-term care task force, area agencies on aging, and representatives of consumers, providers, and labor unions. Within the limits of available appropriations, the commissioners may employ consultants to assist with this project.

Subd. 2. **Quality measurement tools.** The commissioners shall identify and apply existing quality measurement tools to:

(1) emphasize quality of care and its relationship to quality of life; and

(2) address the needs of various users of long-term care services, including, but not limited to, short-stay residents, persons with behavioral problems, persons with dementia, and persons who are members of minority groups.

The tools must be identified and applied, to the extent possible, without requiring providers to supply information beyond current state and federal requirements.

Subd. 3. **Consumer surveys.** Following identification of the quality measurement tool, the commissioners shall conduct surveys of long-term care service consumers to develop quality profiles of providers. To the extent possible, surveys must be conducted face-to-face by state employees or contractors. At the discretion of the commissioners, surveys may be conducted by telephone or by provider staff. Surveys must be conducted periodically to update quality profiles of individual service providers.

Subd. 4. **Dissemination of quality profiles.** By July 1, 2002, the commissioners shall implement a system to disseminate the quality profiles developed from consumer surveys using the quality measurement tool. Profiles may be disseminated to the Senior LinkAge line and to consumers, providers, and purchasers of long-term care services through all feasible printed and electronic outlets. The commissioners may conduct a public awareness campaign to inform potential users regarding profile contents and potential uses.

History: *1Sp2001 c 9 art 5 s 29*

256B.49 CHRONICALLY ILL CHILDREN AND DISABLED PERSONS; HOME AND COMMUNITY-BASED WAIVER STUDY AND APPLICATION.

Subdivision 1. [Repealed, 1Sp2001 c 9 art 3 s 76]

Subd. 2. [Repealed, 1Sp2001 c 9 art 3 s 76]

Subd. 3. [Repealed, 1Sp2001 c 9 art 3 s 76]

Subd. 4. [Repealed, 1Sp2001 c 9 art 3 s 76]

Subd. 5. [Repealed, 1Sp2001 c 9 art 3 s 76]

Subd. 6. [Repealed, 1Sp2001 c 9 art 3 s 76]

Subd. 7. [Repealed, 1Sp2001 c 9 art 3 s 76]

Subd. 8. [Repealed, 1Sp2001 c 9 art 3 s 76]

Subd. 9. [Repealed, 1Sp2001 c 9 art 3 s 76]

Subd. 10. [Repealed, 1Sp2001 c 9 art 3 s 76]

Subd. 11. **Authority.** (a) The commissioner is authorized to apply for home and community-based service waivers, as authorized under section 1915(c) of the Social Security Act to serve persons under the age of 65 who are determined to require the level of care provided in a nursing home and persons who require the level of care provided in a hospital. The commissioner shall apply for the home and community-based waivers in order to:

(i) promote the support of persons with disabilities in the most integrated settings;

(ii) expand the availability of services for persons who are eligible for medical assistance;

(iii) promote cost-effective options to institutional care; and

(iv) obtain federal financial participation.

(b) The provision of waivered services to medical assistance recipients with disabilities shall comply with the requirements outlined in the federally approved applications for home and community-based services and subsequent amendments, including provision of services according to a service plan designed to meet the needs of the individual. For purposes of this section, the approved home and community-based application is considered the necessary federal requirement.

(c) The commissioner shall provide interested persons serving on agency advisory committees and task forces, and others upon request, with notice of, and an opportunity to comment on, any changes or amendments to the federally approved applications for home and community-based waivers, prior to their submission to the federal health care financing administration.

(d) The commissioner shall seek approval, as authorized under section 1915(c) of the Social Security Act, to allow medical assistance eligibility under this section for children under age 21 without deeming of parental income or assets.

(e) The commissioner shall seek approval, as authorized under section 1915(c) of the Social Act, to allow medical assistance eligibility under this section for individuals under age 65 without deeming the spouse's income or assets.

Subd. 12. **Informed choice.** Persons who are determined likely to require the level of care provided in a nursing facility or hospital shall be informed of the home and community-based support alternatives to the provision of inpatient hospital services or nursing facility services. Each person must be given the choice of either institutional or home and community-based services using the provisions described in section 256B.77, subdivision 2, paragraph (p).

Subd. 13. **Case management.** (a) Each recipient of a home and community-based waiver shall be provided case management services by qualified vendors as described in the federally approved waiver application. The case management service activities provided will include:

(1) assessing the needs of the individual within 20 working days of a recipient's request;

(2) developing the written individual service plan within ten working days after the assessment is completed;

(3) informing the recipient or the recipient's legal guardian or conservator of service options;

(4) assisting the recipient in the identification of potential service providers;

(5) assisting the recipient to access services;

(6) coordinating, evaluating, and monitoring of the services identified in the service plan;

(7) completing the annual reviews of the service plan; and

(8) informing the recipient or legal representative of the right to have assessments completed and service plans developed within specified time periods, and to appeal county action or inaction under section 256.045, subdivision 3.

(b) The case manager may delegate certain aspects of the case management service activities to another individual provided there is oversight by the case manager. The case manager may not delegate those aspects which require professional judgment including assessments, reassessments, and care plan development.

Subd. 14. **Assessment and reassessment.** (a) Assessments of each recipient's strengths, informal support systems, and need for services shall be completed within 20 working days of the recipient's request. Reassessment of each recipient's strengths, support systems, and need for services shall be conducted at least every 12 months and at other times when there has been a significant change in the recipient's functioning.

(b) Persons with mental retardation or a related condition who apply for services under the nursing facility level waiver programs shall be screened for the appropriate level of care according to section 256B.092.

(c) Recipients who are found eligible for home and community-based services under this section before their 65th birthday may remain eligible for these services after their 65th birthday if they continue to meet all other eligibility factors.

Subd. 15. **Individualized service plan.** Each recipient of home and community-based waivered services shall be provided a copy of the written service plan which:

(1) is developed and signed by the recipient within ten working days of the completion of the assessment;

(2) meets the assessed needs of the recipient;

(3) reasonably ensures the health and safety of the recipient;

(4) promotes independence;

(5) allows for services to be provided in the most integrated settings; and

(6) provides for an informed choice, as defined in section 256B.77, subdivision 2, paragraph (p), of service and support providers.

Subd. 16. **Services and supports.** (a) Services and supports included in the home and community-based waivers for persons with disabilities shall meet the requirements set out in United States Code, title 42, section 1396n. The services and supports, which are offered as alternatives to institutional care, shall promote consumer choice, community inclusion, self-sufficiency, and self-determination.

(b) Beginning January 1, 2003, the commissioner shall simplify and improve access to home and community-based waivered services, to the extent possible, through the establishment of a common service menu that is available to eligible recipients regardless of age, disability type, or waiver program.

(c) Consumer directed community support services shall be offered as an option to all persons eligible for services under subdivision 11, by January 1, 2002.

(d) Services and supports shall be arranged and provided consistent with individualized written plans of care for eligible waiver recipients.

(e) The state of Minnesota and county agencies that administer home and community-based waivered services for persons with disabilities, shall not be liable for damages, injuries, or liabilities sustained through the purchase of supports by the individual, the individual's family, legal representative, or the authorized representative with funds received through the consumer-directed community support service under this section. Liabilities include but are not limited to: workers' compensation liability, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA).

Subd. 17. **Cost of services and supports.** (a) The commissioner shall ensure that the average per capita expenditures estimated in any fiscal year for home and community-based waiver recipients does not exceed the average per capita expenditures that would have been made to provide institutional services for recipients in the absence of the waiver.

(b) The commissioner shall implement on January 1, 2002, one or more aggregate, need-based methods for allocating to local agencies the home and community-based waivered service resources available to support recipients with disabilities in need of

the level of care provided in a nursing facility or a hospital. The commissioner shall allocate resources to single counties and county partnerships in a manner that reflects consideration of:

(1) an incentive-based payment process for achieving outcomes;

(2) the need for a state-level risk pool;

(3) the need for retention of management responsibility at the state agency level; and

(4) a phase-in strategy as appropriate.

(c) Until the allocation methods described in paragraph (b) are implemented, the annual allowable reimbursement level of home and community-based waiver services shall be the greater of:

(1) the statewide average payment amount which the recipient is assigned under the waiver reimbursement system in place on June 30, 2001, modified by the percentage of any provider rate increase appropriated for home and community-based services; or

(2) an amount approved by the commissioner based on the recipient's extraordinary needs that cannot be met within the current allowable reimbursement level. The increased reimbursement level must be necessary to allow the recipient to be discharged from an institution or to prevent imminent placement in an institution. The additional reimbursement may be used to secure environmental modifications; assistive technology and equipment; and increased costs for supervision, training, and support services necessary to address the recipient's extraordinary needs. The commissioner may approve an increased reimbursement level for up to one year of the recipient's relocation from an institution or up to six months of a determination that a current waiver recipient is at imminent risk of being placed in an institution.

(d) Beginning July 1, 2001, medically necessary private duty nursing services will be authorized under this section as complex and regular care according to section 256B.0627. The rate established by the commissioner for registered nurse or licensed practical nurse services under any home and community-based waiver as of January 1, 2001, shall not be reduced.

Subd. 18. **Payments.** The commissioner shall reimburse approved vendors from the medical assistance account for the costs of providing home and community-based services to eligible recipients using the invoice processing procedures of the Medicaid management information system (MMIS). Recipients will be screened and authorized for services according to the federally approved waiver application and its subsequent amendments.

Subd. 19. **Health and welfare.** The commissioner of human services shall take the necessary safeguards to protect the health and welfare of individuals provided services under the waiver.

Subd. 20. **Traumatic brain injury and related conditions.** The commissioner shall seek to amend the traumatic brain injury waiver to include, as eligible persons, individuals with an acquired or degenerative disease diagnosis where cognitive impairment is present, such as multiple sclerosis.

History: *1Sp2001 c 9 art 3 s 58-67*

256B.50 APPEALS.

Subdivision 1. **Scope.** A provider may appeal from a determination of a payment rate established pursuant to this chapter and reimbursement rules of the commissioner if the appeal, if successful, would result in a change to the provider's payment rate or to the calculation of maximum charges to therapy vendors as provided by section 256B.433, subdivision 3. Appeals must be filed in accordance with procedures in this section. This section does not apply to a request from a resident or long-term care facility for reconsideration of the classification of a resident under section 144.0722.

[For text of subds 1a to 1f, see M.S.2000]

History: *2001 c 7 s 51*

256B.501 RATES FOR COMMUNITY-BASED SERVICES FOR PERSONS WITH MENTAL RETARDATION OR RELATED CONDITIONS.

[For text of subds 1 to 4b, see M.S.2000]

Subd. 4c. **Access to respite care.** Upon the request of a recipient receiving services under the community-based waiver for persons with mental retardation and related conditions, or the recipient's legal representative, a county agency shall screen the recipient for appropriate and necessary services and shall place the recipient on and off the waiver as needed in order to allow the recipient access to short-term care as available in an intermediate care facility for persons with mental retardation and related conditions.

[For text of subds 5a to 13, see M.S.2000]

History: *2001 c 35 s 1*

256B.5012 ICF/MR PAYMENT SYSTEM IMPLEMENTATION.

[For text of subds 1 to 3, see M.S.2000]

Subd. 4. **ICF/MR rate increases beginning July 1, 2001, and July 1, 2002.** (a) For the rate years beginning July 1, 2001, and July 1, 2002, the commissioner shall make available to each facility reimbursed under this section an adjustment to the total operating payment rate of 3.5 percent. Of this adjustment, two-thirds must be used as provided under paragraph (b) and one-third must be used for operating costs.

(b) The adjustment under this paragraph must be used to increase the wages and benefits and pay associated costs of all employees except administrative and central office employees, provided that this increase must be used only for wage and benefit increases implemented on or after the first day of the rate year and must not be used for increases implemented prior to that date.

(c) For each facility, the commissioner shall make available an adjustment using the percentage specified in paragraph (a) multiplied by the total payment rate, excluding the property-related payment rate, in effect on the preceding June 30. The total payment rate shall include the adjustment provided in section 256B.501, subdivision 12.

(d) A facility whose payment rates are governed by closure agreements, receivership agreements, or Minnesota Rules, part 9553.0075, is not eligible for an adjustment otherwise granted under this subdivision.

(e) A facility may apply for the payment rate adjustment provided under paragraph (b). The application must be made to the commissioner and contain a plan by which the facility will distribute the adjustment in paragraph (b) to employees of the facility. For facilities in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes the plan. A negotiated agreement may constitute the plan only if the agreement is finalized after the date of enactment of all rate increases for the rate year. The commissioner shall review the plan to ensure that the payment rate adjustment per diem is used as provided in this subdivision. To be eligible, a facility must submit its plan by March 31, 2002, and March 31, 2003, respectively. If a facility's plan is effective for its employees after the first day of the applicable rate year that the funds are available, the payment rate adjustment per diem is effective the same date as its plan.

(f) A copy of the approved distribution plan must be made available to all employees by giving each employee a copy or by posting it in an area of the facility to which all employees have access. If an employee does not receive the wage and benefit adjustment described in the facility's approved plan and is unable to resolve the

problem with the facility's management or through the employee's union representative, the employee may contact the commissioner at an address or telephone number provided by the commissioner and included in the approved plan.

History: *1Sp2001 c 9 art 5 s 30*

256B.5013 PAYMENT RATE ADJUSTMENTS.

Subdivision 1. **Variable rate adjustments.** For rate years beginning on or after October 1, 2000, when there is a documented increase in the resource needs of a current ICF/MR recipient or recipients, or a person is admitted to a facility who requires additional resources, the county of financial responsibility may recommend approval of a variable rate to enable the facility to meet the individual's increased needs. Variable rate adjustments made under this subdivision replace payments for persons with special needs under section 256B.501, subdivision 8, and payments for persons with special needs for crisis intervention services under section 256B.501, subdivision 8a. Resource needs directly attributable to an individual that may be considered under the variable rate adjustment include increased direct staff hours, other specialized services, and equipment. The guidelines in paragraphs (a) to (d) apply for the payment rate adjustments under this section.

(a) All persons must be screened according to section 256B.092, subdivisions 7 and 8, prior to implementation of the new payment system, and annually thereafter, and when a variable rate is being requested due to changes in the needs of the recipient. Screening data shall be used to monitor changes as follows:

(1) the functional ability of a recipient to care for and maintain the recipient's own basic needs;

(2) the intensity of any aggressive or destructive behavior; and

(3) any history of obstructive behavior in combination with a diagnosis of psychosis or neurosis.

(b) A variable rate may be recommended for increased service needs such as:

(1) a need for resources due to a change in resident day program participation because the resident: (i) has reached the age of 65 or has a change in health condition that makes it difficult for the person to participate in day training and habilitation services over an extended period of time because it is medically contraindicated; and (ii) has expressed a desire for change through the mental retardation and related conditions screening process under section 256B.092; and

(2) a need for additional resources for intensive short-term programming which is necessary prior to a recipient's discharge to a less restrictive, more integrated setting.

Recommendations for a variable rate shall be used to link resource needs to funding. The variable rate must be applied to expenses related to increased direct staff hours, other specialized services, and equipment.

(c) A recipient must be screened by the county of financial responsibility using the developmental disabilities screening document completed immediately prior to approval of a variable rate by the county. A comparison of the updated screening and the previous screening must demonstrate an increase in resource needs.

(d) Rate adjustments projected to exceed the authorized funding level associated with the person's profile must be submitted to the commissioner.

(e) The county of financial responsibility must indicate the projected length of time that the additional funding may be needed for the individual. The need to continue an individual variable rate must be reviewed at the end of the anticipated duration of need but at least annually through the completion of the developmental disabilities screening document.

[For text of subds 2 to 6, see M.S.2000]

History: *2001 c 203 s 13*

256B.53 DENTAL ACCESS GRANTS.

(a) The commissioner shall award grants to community clinics or other nonprofit community organizations, political subdivisions, professional associations, or other organizations that demonstrate the ability to provide dental services effectively to public program recipients. Grants may be used to fund the costs related to coordinating access for recipients, developing and implementing patient care criteria, upgrading or establishing new facilities, acquiring furnishings or equipment, recruiting new providers, or other development costs that will improve access to dental care in a region.

(b) In awarding grants, the commissioner shall give priority to applicants that plan to serve areas of the state in which the number of dental providers is not currently sufficient to meet the needs of recipients of public programs or uninsured individuals. The commissioner shall consider the following in awarding the grants:

(1) potential to successfully increase access to an underserved population;

(2) the long-term viability of the project to improve access beyond the period of initial funding;

(3) the efficiency in the use of the funding; and

(4) the experience of the applicants in providing services to the target population.

(c) The commissioner shall consider grants for the following:

(1) implementation of new programs or continued expansion of current access programs that have demonstrated success in providing dental services in underserved areas;

(2) a program for mobile or other types of outreach dental clinics in underserved geographic areas;

(3) a program for school-based dental clinics in schools with high numbers of children receiving medical assistance;

(4) a program testing new models of care that are sensitive to the cultural needs of the recipients;

(5) a program creating new educational campaigns that inform individuals of the importance of good oral health and the link between dental disease and overall health status;

(6) a program that organizes a network of volunteer dentists to provide dental services to public program recipients or uninsured individuals; and

(7) a program that tests new delivery models by creating partnerships between local providers and county public health agencies.

(d) The commissioner shall evaluate the effects of the dental access initiatives funded through the dental access grants and submit a report to the legislature by January 15, 2003.

History: *1Sp2001 c 9 art 2 s 47*

256B.55 DENTAL ACCESS ADVISORY COMMITTEE.

Subdivision 1. **Establishment.** The commissioner shall establish a dental access advisory committee to monitor the purchasing, administration, and coverage of dental care services for the public health care programs to ensure dental care access and quality for public program recipients.

Subd. 2. **Membership.** (a) The membership of the advisory committee shall include, but is not limited to, representatives of dentists, including a dentist practicing in the seven-county metropolitan area and a dentist practicing outside the seven-county metropolitan area; oral surgeons; pediatric dentists; dental hygienists; community clinics; client advocacy groups; public health; health service plans; the University of Minnesota school of dentistry and the department of pediatrics; and the commissioner of health.

(b) The advisory committee is governed by section 15.059 for membership terms and removal of members. Members shall not receive per diem compensation or reimbursement for expenses.

Subd. 3. **Duties.** The advisory committee shall provide recommendations on the following:

(1) how to reduce the administrative burden governing dental care coverage policies in order to promote administrative simplification, including prior authorization, coverage limits, and co-payment collections;

(2) developing and implementing an action plan to improve the oral health of children and persons with special needs in the state;

(3) exploring alternative ways of purchasing and improving access to dental services;

(4) developing ways to foster greater responsibility among health care program recipients in seeking and obtaining dental care, including initiatives to keep dental appointments and comply with dental care plans;

(5) exploring innovative ways for dental providers to schedule public program patients in order to reduce or minimize the effect of appointment no shows;

(6) exploring ways to meet the barriers that may be present in providing dental services to health care program recipients such as language, culture, disability, and lack of transportation; and

(7) exploring the possibility of pediatricians, family physicians, and nurse practitioners providing basic oral health screenings and basic preventive dental services.

Subd. 4. **Report.** The commissioner shall submit a report by February 1, 2002, and by February 1, 2003, summarizing the activities and recommendations of the advisory committee.

Subd. 5. **Sunset.** Notwithstanding section 15.059, subdivision 5, this section expires June 30, 2003.

History: *1Sp2001 c 9 art 2 s 48*

256B.69 PREPAYMENT DEMONSTRATION PROJECT.

[For text of subds 1 to 3, see M.S.2000]

Subd. 3a. **County authority.** (a) The commissioner, when implementing the general assistance medical care, or medical assistance prepayment program within a county, must include the county board in the process of development, approval, and issuance of the request for proposals to provide services to eligible individuals within the proposed county. County boards must be given reasonable opportunity to make recommendations regarding the development, issuance, review of responses, and changes needed in the request for proposals. The commissioner must provide county boards the opportunity to review each proposal based on the identification of community needs under chapters 145A and 256E and county advocacy activities. If a county board finds that a proposal does not address certain community needs, the county board and commissioner shall continue efforts for improving the proposal and network prior to the approval of the contract. The county board shall make recommendations regarding the approval of local networks and their operations to ensure adequate availability and access to covered services. The provider or health plan must respond directly to county advocates and the state prepaid medical assistance ombudsperson regarding service delivery and must be accountable to the state regarding contracts with medical assistance and general assistance medical care funds. The county board may recommend a maximum number of participating health plans after considering the size of the enrolling population; ensuring adequate access and capacity; considering the client and county administrative complexity; and considering the need to promote the viability of locally developed health plans. The county board or a single entity representing a group of county boards and the commissioner shall mutually select health plans for participation at the time of initial implementation of the prepaid medical assistance program in that county or group of counties and at the time of contract renewal. The commissioner shall also seek input for contract requirements from the county or single entity representing a group of county boards at each contract renewal and incorporate those recommendations into the contract negotiation process. The commissioner, in conjunc-

tion with the county board, shall actively seek to develop a mutually agreeable timetable prior to the development of the request for proposal, but counties must agree to initial enrollment beginning on or before January 1, 1999, in either the prepaid medical assistance and general assistance medical care programs or county-based purchasing under section 256B.692. At least 90 days before enrollment in the medical assistance and general assistance medical care prepaid programs begins in a county in which the prepaid programs have not been established, the commissioner shall provide a report to the chairs of senate and house committees having jurisdiction over state health care programs which verifies that the commissioner complied with the requirements for county involvement that are specified in this subdivision.

(b) At the option of the county board, the board may develop contract requirements related to the achievement of local public health goals to meet the health needs of medical assistance and general assistance medical care enrollees. These requirements must be reasonably related to the performance of health plan functions and within the scope of the medical assistance and general assistance medical care benefit sets. If the county board and the commissioner mutually agree to such requirements, the department shall include such requirements in all health plan contracts governing the prepaid medical assistance and general assistance medical care programs in that county at initial implementation of the program in that county and at the time of contract renewal. The county board may participate in the enforcement of the contract provisions related to local public health goals.

(c) For counties in which prepaid medical assistance and general assistance medical care programs have not been established, the commissioner shall not implement those programs if a county board submits acceptable and timely preliminary and final proposals under section 256B.692, until county-based purchasing is no longer operational in that county. For counties in which prepaid medical assistance and general assistance medical care programs are in existence on or after September 1, 1997, the commissioner must terminate contracts with health plans according to section 256B.692, subdivision 5, if the county board submits and the commissioner accepts preliminary and final proposals according to that subdivision. The commissioner is not required to terminate contracts that begin on or after September 1, 1997, according to section 256B.692 until two years have elapsed from the date of initial enrollment.

(d) In the event that a county board or a single entity representing a group of county boards and the commissioner cannot reach agreement regarding: (i) the selection of participating health plans in that county; (ii) contract requirements; or (iii) implementation and enforcement of county requirements including provisions regarding local public health goals, the commissioner shall resolve all disputes after taking into account the recommendations of a three-person mediation panel. The panel shall be composed of one designee of the president of the association of Minnesota counties, one designee of the commissioner of human services, and one designee of the commissioner of health.

(e) If a county which elects to implement county-based purchasing ceases to implement county-based purchasing, it is prohibited from assuming the responsibility of county-based purchasing for a period of five years from the date it discontinues purchasing.

(f) Notwithstanding the requirement in this subdivision that a county must agree to initial enrollment on or before January 1, 1999, the commissioner shall grant a delay in the implementation of the county-based purchasing authorized in section 256B.692 until federal waiver authority and approval has been granted, if the county or group of counties has submitted a preliminary proposal for county-based purchasing by September 1, 1997, has not already implemented the prepaid medical assistance program before January 1, 1998, and has submitted a written request for the delay to the commissioner by July 1, 1998. In order for the delay to be continued, the county or group of counties must also submit to the commissioner the following information by December 1, 1998. The information must:

(1) identify the proposed date of implementation, as determined under section 256B.692, subdivision 5;

(2) include copies of the county board resolutions which demonstrate the continued commitment to the implementation of county-based purchasing by the proposed date. County board authorization may remain contingent on the submission of a final proposal which meets the requirements of section 256B.692, subdivision 5, paragraph (b);

(3) demonstrate actions taken for the establishment of a governance structure between the participating counties and describe how the fiduciary responsibilities of county-based purchasing will be allocated between the counties, if more than one county is involved in the proposal;

(4) describe how the risk of a deficit will be managed in the event expenditures are greater than total capitation payments. This description must identify how any of the following strategies will be used:

(i) risk contracts with licensed health plans;

(ii) risk arrangements with providers who are not licensed health plans;

(iii) risk arrangements with other licensed insurance entities; and

(iv) funding from other county resources;

(5) include, if county-based purchasing will not contract with licensed health plans or provider networks, letters of interest from local providers in at least the categories of hospital, physician, mental health, and pharmacy which express interest in contracting for services. These letters must recognize any risk transfer identified in clause (4), item (ii); and

(6) describe the options being considered to obtain the administrative services required in section 256B.692, subdivision 3, clauses (3) and (5).

(g) For counties which receive a delay under this subdivision, the final proposals required under section 256B.692, subdivision 5, paragraph (b), must be submitted at least six months prior to the requested implementation date. Authority to implement county-based purchasing remains contingent on approval of the final proposal as required under section 256B.692.

(h) If the commissioner is unable to provide county-specific, individual-level fee-for-service claims to counties by June 4, 1998, the commissioner shall grant a delay under paragraph (f) of up to 12 months in the implementation of county-based purchasing, and shall require implementation not later than January 1, 2000. In order to receive an extension of the proposed date of implementation under this paragraph, a county or group of counties must submit a written request for the extension to the commissioner by August 1, 1998, must submit the information required under paragraph (f) by December 1, 1998, and must submit a final proposal as provided under paragraph (g).

(i) Notwithstanding other requirements of this subdivision, the commissioner shall not require the implementation of the county-based purchasing authorized in section 256B.692 until six months after federal waiver approval has been obtained for county-based purchasing, if the county or counties have submitted the final plan as required in section 256B.692, subdivision 5. The commissioner shall allow the county or counties which submitted information under section 256B.692, subdivision 5, to submit supplemental or additional information which was not possible to submit by April 1, 1999. A county or counties shall continue to submit the required information and substantive detail necessary to obtain a prompt response and waiver approval. If amendments to the final plan are necessary due to the terms and conditions of the waiver approval, the commissioner shall allow the county or group of counties 60 days to make the necessary amendments to the final plan and shall not require implementation of the county-based purchasing until six months after the revised final plan has been submitted.

[For text of subd 3b, see M.S.2000]

Subd. 4. **Limitation of choice.** (a) The commissioner shall develop criteria to determine when limitation of choice may be implemented in the experimental counties. The criteria shall ensure that all eligible individuals in the county have continuing access to the full range of medical assistance services as specified in subdivision 6.

(b) The commissioner shall exempt the following persons from participation in the project, in addition to those who do not meet the criteria for limitation of choice:

(1) persons eligible for medical assistance according to section 256B.055, subdivision 1;

(2) persons eligible for medical assistance due to blindness or disability as determined by the social security administration or the state medical review team, unless:

(i) they are 65 years of age or older; or

(ii) they reside in Itasca county or they reside in a county in which the commissioner conducts a pilot project under a waiver granted pursuant to section 1115 of the Social Security Act;

(3) recipients who currently have private coverage through a health maintenance organization;

(4) recipients who are eligible for medical assistance by spending down excess income for medical expenses other than the nursing facility per diem expense;

(5) recipients who receive benefits under the Refugee Assistance Program, established under United States Code, title 8, section 1522(e);

(6) children who are both determined to be severely emotionally disturbed and receiving case management services according to section 256B.0625, subdivision 20;

(7) adults who are both determined to be seriously and persistently mentally ill and received case management services according to section 256B.0625, subdivision 20; and

(8) persons eligible for medical assistance according to section 256B.057, subdivision 10.

Children under age 21 who are in foster placement may enroll in the project on an elective basis. Individuals excluded under clauses (6) and (7) may choose to enroll on an elective basis.

(c) The commissioner may allow persons with a one-month spenddown who are otherwise eligible to enroll to voluntarily enroll or remain enrolled, if they elect to prepay their monthly spenddown to the state.

(d) The commissioner may require those individuals to enroll in the prepaid medical assistance program who otherwise would have been excluded under paragraph (b), clauses (1), (3), and (8), and under Minnesota Rules, part 9500.1452, subpart 2, items H, K, and L.

(e) Before limitation of choice is implemented, eligible individuals shall be notified and after notification, shall be allowed to choose only among demonstration providers. The commissioner may assign an individual with private coverage through a health maintenance organization, to the same health maintenance organization for medical assistance coverage, if the health maintenance organization is under contract for medical assistance in the individual's county of residence. After initially choosing a provider, the recipient is allowed to change that choice only at specified times as allowed by the commissioner. If a demonstration provider ends participation in the project for any reason, a recipient enrolled with that provider must select a new provider but may change providers without cause once more within the first 60 days after enrollment with the second provider.

[For text of subds 4b to 5a, see M.S.2000]

Subd. 5b. **Prospective reimbursement rates.** (a) For prepaid medical assistance and general assistance medical care program contract rates set by the commissioner under

subdivision 5 and effective on or after January 1, 1998, capitation rates for nonmetropolitan counties shall on a weighted average be no less than 88 percent of the capitation rates for metropolitan counties, excluding Hennepin county. The commissioner shall make a pro rata adjustment in capitation rates paid to counties other than nonmetropolitan counties in order to make this provision budget neutral.

(b) For prepaid medical assistance program contract rates set by the commissioner under subdivision 5 and effective on or after January 1, 2001, capitation rates for nonmetropolitan counties shall, on a weighted average, be no less than 89 percent of the capitation rates for metropolitan counties, excluding Hennepin county.

(c) This subdivision shall not affect the nongeographically based risk adjusted rates established under section 62Q.03, subdivision 5a.

Subd. 5c. **Medical education and research fund.** (a) The commissioner of human services shall transfer each year to the medical education and research fund established under section 62J.692, the following:

(1) an amount equal to the reduction in the prepaid medical assistance and prepaid general assistance medical care payments as specified in this clause. Until January 1, 2002, the county medical assistance and general assistance medical care capitation base rate prior to plan specific adjustments and after the regional rate adjustments under section 256B.69, subdivision 5b, is reduced 6.3 percent for Hennepin county, two percent for the remaining metropolitan counties, and no reduction for nonmetropolitan Minnesota counties; and after January 1, 2002, the county medical assistance and general assistance medical care capitation base rate prior to plan specific adjustments is reduced 6.3 percent for Hennepin county, two percent for the remaining metropolitan counties, and 1.6 percent for nonmetropolitan Minnesota counties. Nursing facility and elderly waiver payments and demonstration project payments operating under subdivision 23 are excluded from this reduction. The amount calculated under this clause shall not be adjusted for periods already paid due to subsequent changes to the capitation payments; and

(2) beginning July 1, 2001, $2,537,000 from the capitation rates paid under this section plus any federal matching funds on this amount.

(b) This subdivision shall be effective upon approval of a federal waiver which allows federal financial participation in the medical education and research fund.

[For text of subds 5d to 6b, see M.S.2000]

Subd. 6c. **Dental services demonstration project.** The commissioner shall establish a dental services demonstration project in Crow Wing, Todd, Morrison, Wadena, and Cass counties for provision of dental services to medical assistance, general assistance medical care, and MinnesotaCare recipients. The commissioner may contract on a prospective per capita payment basis for these dental services with an organization licensed under chapter 62C, 62D, or 62N in accordance with section 256B.037 or may establish and administer a fee-for-service system for the reimbursement of dental services.

[For text of subds 7 to 22, see M.S.2000]

Subd. 23. **Alternative integrated long-term care services; elderly and disabled persons.** (a) The commissioner may implement demonstration projects to create alternative integrated delivery systems for acute and long-term care services to elderly persons and persons with disabilities as defined in section 256B.77, subdivision 7a, that provide increased coordination, improve access to quality services, and mitigate future cost increases. The commissioner may seek federal authority to combine Medicare and Medicaid capitation payments for the purpose of such demonstrations. Medicare funds and services shall be administered according to the terms and conditions of the federal waiver and demonstration provisions. For the purpose of administering medical assistance funds, demonstrations under this subdivision are subject to subdivisions 1 to 22. The provisions of Minnesota Rules, parts 9500.1450 to 9500.1464, apply to these demonstrations, with the exceptions of parts 9500.1452, subpart 2, item B; and

9500.1457, subpart 1, items B and C, which do not apply to persons enrolling in demonstrations under this section. An initial open enrollment period may be provided. Persons who disenroll from demonstrations under this subdivision remain subject to Minnesota Rules, parts 9500.1450 to 9500.1464. When a person is enrolled in a health plan under these demonstrations and the health plan's participation is subsequently terminated for any reason, the person shall be provided an opportunity to select a new health plan and shall have the right to change health plans within the first 60 days of enrollment in the second health plan. Persons required to participate in health plans under this section who fail to make a choice of health plan shall not be randomly assigned to health plans under these demonstrations. Notwithstanding section 256L.12, subdivision 5, and Minnesota Rules, part 9505.5220, subpart 1, item A, if adopted, for the purpose of demonstrations under this subdivision, the commissioner may contract with managed care organizations, including counties, to serve only elderly persons eligible for medical assistance, elderly and disabled persons, or disabled persons only. For persons with primary diagnoses of mental retardation or a related condition, serious and persistent mental illness, or serious emotional disturbance, the commissioner must ensure that the county authority has approved the demonstration and contracting design. Enrollment in these projects for persons with disabilities shall be voluntary. The commissioner shall not implement any demonstration project under this subdivision for persons with primary diagnoses of mental retardation or a related condition, serious and persistent mental illness, or serious emotional disturbance, without approval of the county board of the county in which the demonstration is being implemented.

Before implementation of a demonstration project for disabled persons, the commissioner must provide information to appropriate committees of the house of representatives and senate and must involve representatives of affected disability groups in the design of the demonstration projects.

(b) A nursing facility reimbursed under the alternative reimbursement methodology in section 256B.434 may, in collaboration with a hospital, clinic, or other health care entity provide services under paragraph (a). The commissioner shall amend the state plan and seek any federal waivers necessary to implement this paragraph.

[For text of subds 24a to 27, see M.S.2000]

History: *2001 c 161 s 49; 2001 c 203 s 14; 1Sp2001 c 9 art 2 s 49-52*

NOTE: The amendment to subdivision 4 by Laws 2001, First Special Session chapter 9, article 2, section 49, is effective July 1, 2002. Laws 2001, First Special Session chapter 9, article 2, section 49, the effective date.

256B.692 COUNTY-BASED PURCHASING.

[For text of subd 1, see M.S.2000]

Subd. 2. **Duties of the commissioner of health.** (a) Notwithstanding chapters 62D and 62N, a county that elects to purchase medical assistance and general assistance medical care in return for a fixed sum without regard to the frequency or extent of services furnished to any particular enrollee is not required to obtain a certificate of authority under chapter 62D or 62N. The county board of commissioners is the governing body of a county-based purchasing program. In a multicounty arrangement, the governing body is a joint powers board established under section 471.59.

(b) A county that elects to purchase medical assistance and general assistance medical care services under this section must satisfy the commissioner of health that the requirements for assurance of consumer protection, provider protection, and fiscal solvency of chapter 62D, applicable to health maintenance organizations, or chapter 62N, applicable to community integrated service networks, will be met.

(c) A county must also assure the commissioner of health that the requirements of sections 62J.041; 62J.48; 62J.71 to 62J.73; 62M.01 to 62M.16; all applicable provisions of chapter 62Q, including sections 62Q.075; 62Q.1055; 62Q.106; 62Q.12; 62Q.135; 62Q.14; 62Q.145; 62Q.19; 62Q.23, paragraph (c); 62Q.43; 62Q.47; 62Q.50; 62Q.52 to 62Q.56; 62Q.58; 62Q.64; 62Q.68 to 62Q.72; and 72A.201 will be met.

(d) All enforcement and rulemaking powers available under chapters 62D, 62J, 62M, 62N, and 62Q are hereby granted to the commissioner of health with respect to counties that purchase medical assistance and general assistance medical care services under this section.

(e) The commissioner, in consultation with county government, shall develop administrative and financial reporting requirements for county-based purchasing programs relating to sections 62D.041, 62D.042, 62D.045, 62D.08, 62N.28, 62N.29, and 62N.31, and other sections as necessary, that are specific to county administrative, accounting, and reporting systems and consistent with other statutory requirements of counties.

[For text of subds 3 to 10, see M.S.2000]

History: *2001 c 170 s 8*

256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.

(a) For outpatient hospital facility fee payments for services rendered on or after October 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge, or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for which there is a federal maximum allowable payment. Effective for services rendered on or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and emergency room facility fees shall be increased by eight percent over the rates in effect on December 31, 1999, except for those services for which there is a federal maximum allowable payment. Services for which there is a federal maximum allowable payment shall be paid at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare upper limit. If it is determined that a provision of this section conflicts with existing or future requirements of the United States government with respect to federal financial participation in medical assistance, the federal requirements prevail. The commissioner may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial participation resulting from rates that are in excess of the Medicare upper limitations.

(b) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory surgery hospital facility fee services for critical access hospitals designated under section 144.1483, clause (11), shall be paid on a cost-based payment system that is based on the cost-finding methods and allowable costs of the Medicare program.

(c) Effective for services provided on or after July 1, 2002, rates that are based on the Medicare outpatient prospective payment system shall be replaced by a budget neutral prospective payment system that is derived using medical assistance data. The commissioner shall provide a proposal to the 2002 legislature to define and implement this provision.

History: *1Sp2001 c 9 art 2 s 53*

256B.76 PHYSICIAN AND DENTAL REIMBURSEMENT.

(a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for physician services as follows:

(1) payment for level one Health Care Finance Administration's common procedural coding system (HCPCS) codes titled "office and other outpatient services," "preventive medicine new and established patient," "delivery, antepartum, and postpartum care," "critical care," cesarean delivery and pharmacologic management provided to psychiatric patients, and HCPCS level three codes for enhanced services for prenatal high risk, shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992. If the rate on any procedure code within these categories is different than the rate that would have been paid under the methodology in section 256B.74, subdivision 2, then the larger rate shall be paid;

(2) payments for all other services shall be paid at the lower of (i) submitted charges, or (ii) 15.4 percent above the rate in effect on June 30, 1992;

(3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases except that payment rates for home health agency services shall be the rates in effect on September 30, 1992;

(4) effective for services rendered on or after January 1, 2000, payment rates for physician and professional services shall be increased by three percent over the rates in effect on December 31, 1999, except for home health agency and family planning agency services; and

(5) the increases in clause (4) shall be implemented January 1, 2000, for managed care.

(b) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for dental services as follows:

(1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992;

(2) dental rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases;

(3) effective for services rendered on or after January 1, 2000, payment rates for dental services shall be increased by three percent over the rates in effect on December 31, 1999;

(4) the commissioner shall award grants to community clinics or other nonprofit community organizations, political subdivisions, professional associations, or other organizations that demonstrate the ability to provide dental services effectively to public program recipients. Grants may be used to fund the costs related to coordinating access for recipients, developing and implementing patient care criteria, upgrading or establishing new facilities, acquiring furnishings or equipment, recruiting new providers, or other development costs that will improve access to dental care in a region. In awarding grants, the commissioner shall give priority to applicants that plan to serve areas of the state in which the number of dental providers is not currently sufficient to meet the needs of recipients of public programs or uninsured individuals. The commissioner shall consider the following in awarding the grants:

(i) potential to successfully increase access to an underserved population;

(ii) the ability to raise matching funds;

(iii) the long-term viability of the project to improve access beyond the period of initial funding;

(iv) the efficiency in the use of the funding; and

(v) the experience of the proposers in providing services to the target population.

The commissioner shall monitor the grants and may terminate a grant if the grantee does not increase dental access for public program recipients. The commissioner shall consider grants for the following:

(i) implementation of new programs or continued expansion of current access programs that have demonstrated success in providing dental services in underserved areas;

(ii) a pilot program for utilizing hygienists outside of a traditional dental office to provide dental hygiene services; and

(iii) a program that organizes a network of volunteer dentists, establishes a system to refer eligible individuals to volunteer dentists, and through that network provides donated dental care services to public program recipients or uninsured individuals;

(5) beginning October 1, 1999, the payment for tooth sealants and fluoride treatments shall be the lower of (i) submitted charge, or (ii) 80 percent of median 1997 charges;

(6) the increases listed in clauses (3) and (5) shall be implemented January 1, 2000, for managed care; and

(7) effective for services provided on or after January 1, 2002, payment for diagnostic examinations and dental x-rays provided to children under age 21 shall be the lower of (i) the submitted charge, or (ii) 85 percent of median 1999 charges.

(c) Effective for dental services rendered on or after January 1, 2002, the commissioner may, within the limits of available appropriation, increase reimbursements to dentists and dental clinics deemed by the commissioner to be critical access dental providers. Reimbursement to a critical access dental provider may be increased by not more than 50 percent above the reimbursement rate that would otherwise be paid to the provider. Payments to health plan companies shall be adjusted to reflect increased reimbursements to critical access dental providers as approved by the commissioner. In determining which dentists and dental clinics shall be deemed critical access dental providers, the commissioner shall review:

(1) the utilization rate in the service area in which the dentist or dental clinic operates for dental services to patients covered by medical assistance, general assistance medical care, or MinnesotaCare as their primary source of coverage;

(2) the level of services provided by the dentist or dental clinic to patients covered by medical assistance, general assistance medical care, or MinnesotaCare as their primary source of coverage; and

(3) whether the level of services provided by the dentist or dental clinic is critical to maintaining adequate levels of patient access within the service area.

In the absence of a critical access dental provider in a service area, the commissioner may designate a dentist or dental clinic as a critical access dental provider if the dentist or dental clinic is willing to provide care to patients covered by medical assistance, general assistance medical care, or MinnesotaCare at a level which significantly increases access to dental care in the service area.

(d) An entity that operates both a Medicare certified comprehensive outpatient rehabilitation facility and a facility which was certified prior to January 1, 1993, that is licensed under Minnesota Rules, parts 9570.2000 to 9570.3600, and for whom at least 33 percent of the clients receiving rehabilitation services in the most recent calendar year are medical assistance recipients, shall be reimbursed by the commissioner for rehabilitation services at rates that are 38 percent greater than the maximum reimbursement rate allowed under paragraph (a), clause (2), when those services are (1) provided within the comprehensive outpatient rehabilitation facility and (2) provided to residents of nursing facilities owned by the entity.

History: *1Sp2001 c 9 art 2 s 54*

256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.

Effective for services rendered on or after July 1, 2001, payment for medication management provided to psychiatric patients, outpatient mental health services, day treatment services, home-based mental health services, and family community support services shall be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the 50th percentile of 1999 charges.

History: *1Sp2001 c 9 art 9 s 43*

256B.78 MEDICAL ASSISTANCE DEMONSTRATION PROJECT FOR FAMILY PLANNING SERVICES.

(a) The commissioner of human services shall establish a medical assistance demonstration project to determine whether improved access to coverage of prepregnancy family planning services reduces medical assistance and MFIP costs.

(b) This section is effective upon federal approval of the demonstration project.

History: *1Sp2001 c 9 art 2 s 55*

256B.81 MENTAL HEALTH PROVIDER APPEAL PROCESS.

If a county contract or certification is required to enroll as an authorized provider of mental health services under medical assistance, and if a county refuses to grant the necessary contract or certification, the provider may appeal the county decision to the commissioner. A recipient may initiate an appeal on behalf of a provider who has been denied certification. The commissioner shall determine whether the provider meets applicable standards under state laws and rules based on an independent review of the facts, including comments from the county review. If the commissioner finds that the provider meets the applicable standards, the commissioner shall enroll the provider as an authorized provider. The commissioner shall develop procedures for providers and recipients to appeal a county decision to refuse to enroll a provider. After the commissioner makes a decision regarding an appeal, the county, provider, or recipient may request that the commissioner reconsider the commissioner's initial decision. The commissioner's reconsideration decision is final and not subject to further appeal.

History: *1Sp2001 c 9 art 9 s 44*

256B.82 PREPAID PLANS AND MENTAL HEALTH REHABILITATIVE SERVICES.

Medical assistance and MinnesotaCare prepaid health plans may include coverage for adult mental health rehabilitative services under section 256B.0623 and adult mental health crisis response services under section 256B.0624, beginning January 1, 2004.

By January 15, 2003, the commissioner shall report to the legislature how these services should be included in prepaid plans. The commissioner shall consult with mental health advocates, health plans, and counties in developing this report. The report recommendations must include a plan to ensure coordination of these services between health plans and counties, assure recipient access to essential community providers, and monitor the health plans' delivery of services through utilization review and quality standards.

History: *1Sp2001 c 9 art 9 s 45*

256B.83 MAINTENANCE OF EFFORT FOR CERTAIN MENTAL HEALTH SERVICES.

Any net increase in revenue to the county as a result of the change in section 256B.0623 or 256B.0624 must be used to provide expanded mental health services as defined in sections 245.461 to 245.486, the Comprehensive Adult Mental Health Act, excluding inpatient and residential treatment. Increased revenue may also be used for services and consumer supports, which are part of adult mental health projects approved under section 245.4661. "Increased revenue" has the meaning given in Minnesota Rules, part 9520.0903, subpart 3.

History: *1Sp2001 c 9 art 9 s 46*