Sec. 2. **EFFECTIVE DATE.**

Section 1 is effective June 30, 2002.

Presented to the governor March 22, 2002

Signed by the governor March 25, 2002, 2:16 p.m.

CHAPTER 275—S.F.No. 3100

An act relating to human services; establishing approved tribal health professionals as medical assistance providers; reimbursement for certain health services; American Indian contracting provisions; requiring an evaluation of managed care regional rate differences; authorizing new rate regions; amending Minnesota Statutes 2000, sections 254B.09, subdivision 2; 256B.02, subdivision 7; 256B.32; Minnesota Statutes 2001 Supplement, sections 256B.0644; 256B.69, subdivision 5b; 256B.75; proposing coding for new law in Minnesota Statutes, chapter 256B.

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

Section 1. Minnesota Statutes 2000, section 254B.09, subdivision 2, is amended to read:

Subd. 2. **AMERICAN INDIAN AGREEMENTS.** The commissioner may enter into agreements with federally recognized tribal units to pay for chemical dependency treatment services provided under Laws 1986, chapter 394, sections 8 to 20. The agreements must ~~require~~ clarify how the governing body of the tribal unit ~~to fulfill all county~~ fulfill local agency responsibilities regarding:

(1) selection of eligible vendors under section 254B.03, subdivision 1;

(2) negotiation of agreements that establish vendor services and rates for programs located on the tribal governing body's reservation;

(3) the form and manner of invoicing~~,~~; and

(4) provide that only invoices for eligible vendors according to section 254B.05 will be included in invoices sent to the commissioner for payment, to the extent that money allocated under subdivisions ~~3,~~ 4~~,~~ and 5 is used.

Sec. 2. Minnesota Statutes 2000, section 256B.02, subdivision 7, is amended to read:

Subd. 7. **VENDOR OF MEDICAL CARE.** (a) "Vendor of medical care" means any person or persons furnishing, within the scope of the vendor's respective license, any or all of the following goods or services: medical, surgical, hospital, optical, visual, dental and nursing services; drugs and medical supplies; appliances; laboratory, diagnostic, and therapeutic services; nursing home and convalescent care; screening and health assessment services provided by public health nurses as defined in section 145A.02, subdivision 18; health care services provided at the residence of the patient if the services are performed by a public health nurse and the nurse indicates in a

statement submitted under oath that the services were actually provided; and such other medical services or supplies provided or prescribed by persons authorized by state law to give such services and supplies. The term includes, but is not limited to, directors and officers of corporations or members of partnerships who, either individually or jointly with another or others, have the legal control, supervision, or responsibility of submitting claims for reimbursement to the medical assistance program. The term only includes directors and officers of corporations who personally receive a portion of the distributed assets upon liquidation or dissolution, and their liability is limited to the portion of the claim that bears the same proportion to the total claim as their share of the distributed assets bears to the total distributed assets.

(b) "Vendor of medical care" also includes any person who is credentialed as a health professional under standards set by the governing body of a federally recognized Indian tribe authorized under an agreement with the federal government according to United States Code, title 25, section 450f, to provide health services to its members, and who through a tribal facility provides covered services to American Indian people within a contract health service delivery area of a Minnesota reservation, as defined under Code of Federal Regulations, title 42, section 36.22.

(c) A federally recognized Indian tribe that intends to implement standards for credentialing health professionals must submit the standards to the commissioner of human services, along with evidence of meeting, exceeding, or being exempt from corresponding state standards. The commissioner shall maintain a copy of the standards and supporting evidence, and shall use those standards to enroll tribal-approved health professionals as medical assistance providers. For purposes of this section, "Indian" and "Indian tribe" mean persons or entities that meet the definition in United States Code, title 25, section 450b.

Sec. 3. Minnesota Statutes 2001 Supplement, section 256B.0644, is amended to read:

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) for providers other than dental service providers, 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, or (3) for dental service providers, at least ten 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.

Sec. 4. Minnesota Statutes 2000, section 256B.32, is amended to read:

256B.32 **FACILITY FEE FOR OUTPATIENT HOSPITAL EMERGENCY ROOM AND CLINIC VISITS.**

Subdivision 1. **FACILITY FEE PAYMENT.** The commissioner shall establish a facility fee payment mechanism that will pay a facility fee to all enrolled outpatient hospitals for each emergency room or outpatient clinic visit provided on or after July 1, 1989. This payment mechanism may not result in an overall increase in outpatient payment rates. This section does not apply to federally mandated maximum payment limits, department approved program packages, or services billed using a nonoutpatient hospital provider number.

Subd. 2. **PROSPECTIVE PAYMENT SYSTEM.** Effective for services provided on or after July 1, 2003, 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.

Sec. 5. Minnesota Statutes 2001 Supplement, section 256B.69, subdivision 5b, is amended to read:

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. The commissioner, in consultation with a health care actuary, shall evaluate the regional rate relationships based on actual health plan costs for Minnesota health care programs. The commissioner may establish, based on the actuary's recommendation,

new rate regions that recognize metropolitan areas outside of the seven-county metropolitan area.

(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.

Sec. 6. Minnesota Statutes 2001 Supplement, section 256B.75, is amended to read:

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~~ 2003, 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.

Sec. 7. **[256B.84] AMERICAN INDIAN CONTRACTING PROVISIONS.**

Notwithstanding other state laws or rules, Indian health services and agencies operated by Indian tribes are not required to have a county contract or county certification to enroll as providers of family community support services under section

256B.0625, subdivision 35; therapeutic support of foster care under section 256B.0625, subdivision 36; adult rehabilitative mental health services under section 256B.0623; and adult mental health crisis response services under section 256B.0624. In order to enroll as providers of these services, Indian health services and agencies operated by Indian tribes must meet the vendor of medical care requirements in section 256B.02, subdivision 7.

Presented to the governor March 22, 2002

Signed by the governor March 25, 2002, 2:17 p.m.

CHAPTER 276—S.F.No. 3124

An act relating to health; modifying resident reimbursement classifications; clarifying minimum nursing staff requirements; amending Minnesota Statutes 2000, section 144A.04, subdivision 7; Minnesota Statutes 2001 Supplement, section 144.0724, subdivisions 3, 5, 7, 9.

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

Section 1. Minnesota Statutes 2001 Supplement, section 144.0724, subdivision 3, is amended to read:

Subd. 3. **RESIDENT REIMBURSEMENT CLASSIFICATIONS.** (a) Resident reimbursement classifications shall be based on the minimum data set, version 2.0 assessment instrument, or its successor version mandated by the Health Care Financing Administration that nursing facilities are required to complete for all residents. The commissioner of health shall establish resident classes according to the 34 group, resource utilization groups, version III or RUG-III model. Resident classes must be established based on the individual items on the minimum data set and must be completed according to the facility manual for case mix classification issued by the Minnesota department of health. The facility manual for case mix classification shall be drafted by the Minnesota department of health and presented to the chairs of health and human services legislative committees by December 31, 2001.

(b) Each resident must be classified based on the information from the minimum data set according to general domains in clauses (1) to (7):

(1) extensive services where a resident requires intravenous feeding or medications, suctioning, or tracheostomy care, or is on a ventilator or respirator;

(2) rehabilitation where a resident requires physical, occupational, or speech therapy;

(3) special care where a resident has cerebral palsy; quadriplegia; multiple sclerosis; pressure ulcers; ulcers; fever with vomiting, weight loss, pneumonia, or dehydration; surgical wounds with treatment; or tube feeding and aphasia; or is receiving radiation therapy;