CHAPTER 256B

MEDICAL ASSISTANCE FOR NEEDY PERSONS

256B.031 PREPAID HEALTH PLANS.

[For text of subds 1 to 3, see M.S.1990]

Subd. 4. **Prepaid health plan rates.** For payments made during calendar year 1988, the monthly maximum allowable rate established by the commissioner of human services for payment to prepaid health plans must not exceed 90 percent of the projected average monthly per capita fee-for-service medical assistance costs for state fiscal year 1988 for recipients of aid to families with dependent children. The base year for projecting the average monthly per capita fee-for-service medical assistance costs is state fiscal year 1986. A maximum allowable per capita rate must be established collectively for Anoka, Carver, Dakota, Hennepin, Ramsey, St. Louis, Scott, and Washington counties. A separate maximum allowable per capita rate must be established collectively for all other counties. The maximum allowable per capita rate may be adjusted to reflect utilization differences among eligible classes of recipients. For payments made during calendar year 1989, the maximum allowable rate must be calculated in the same way as 1988 rates, except the base year is state fiscal year 1987. For payments made during calendar year 1990 and later years, the commissioner shall consult with an independent actuary in establishing prepayment rates, but shall retain final control over the rate methodology. Rates established for prepaid health plans must be based on the services that the prepaid health plan provides under contract with the commissioner.

[For text of subds 5 to 10, see M.S.1990]

Subd. 11. **Limitation on reimbursement to providers not affiliated with a prepaid health plan.** A prepaid health plan may limit any reimbursement it may be required to pay to providers not employed by or under contract with the prepaid health plan to the medical assistance rates for medical assistance enrollees, and the general assistance medical care rates for general assistance medical care enrollees, paid by the commissioner of human services to providers for services to recipients not enrolled in a prepaid health plan.

History: *1991 c 292 art 4 s 31,32*

256B.04 DUTIES OF STATE AGENCY.

[For text of subds 1 to 15, see M.S.1990]

Subd. 16. **Personal care services.** (a) Notwithstanding any contrary language in this paragraph, the commissioner of human services and the commissioner of health shall jointly promulgate rules to be applied to the licensure of personal care services provided under the medical assistance program. The rules shall consider standards for personal care services that are based on the World Institute on Disability's recommendations regarding personal care services. These rules shall at a minimum consider the standards and requirements adopted by the commissioner of health under section 144A.45, which the commissioner of human services determines are applicable to the provision of personal care services, in addition to other standards or modifications which the commissioner of human services determines are appropriate.

The commissioner of human services shall establish an advisory group including personal care consumers and providers to provide advice regarding which standards or modifications should be adopted. The advisory group membership must include not less than 15 members, of which at least 60 percent must be consumers of personal care services and representatives of recipients with various disabilities and diagnoses and ages. At least 51 percent of the members of the advisory group must be recipients of personal care.

The commissioner of human services may contract with the commissioner of health to enforce the jointly promulgated licensure rules for personal care service providers.

Prior to final promulgation of the joint rule the commissioner of human services shall report preliminary findings along with any comments of the advisory group and a plan for monitoring and enforcement by the department of health to the legislature by February 15, 1992.

Limits on the extent of personal care services that may be provided to an individual must be based on the cost-effectiveness of the services in relation to the costs of inpatient hospital care, nursing home care, and other available types of care. The rules must provide, at a minimum:

(1) that agencies be selected to contract with or employ and train staff to provide and supervise the provision of personal care services;

(2) that agencies employ or contract with a qualified applicant that a qualified recipient proposes to the agency as the recipient's choice of assistant;

(3) that agencies bill the medical assistance program for a personal care service by a personal care assistant and supervision by the registered nurse supervising the personal care assistant;

(4) that agencies establish a grievance mechanism; and

(5) that agencies have a quality assurance program.

(b) The commissioner may waive the requirement for the provision of personal care services through an agency in a particular county, when there are less than two agencies providing services in that county.

[For text of subd 17, see M.S.1990]

History: *1991 c 292 art 7 s 8*

256B.055 ELIGIBILITY CATEGORIES.

[For text of subds 1 to 9, see M.S.1990]

Subd. 10. **Infants.** Medical assistance may be paid for an infant less than one year of age, whose mother was eligible for and receiving medical assistance at the time of birth and who remains in the mother's household or who is in a family with countable income that is equal to or less than the income standard established under section 256B.057, subdivision 1.

[For text of subd 11, see M.S.1990]

Subd. 12. **Disabled children.** (a) A person is eligible for medical assistance if the person is under age 19 and qualifies as a disabled individual under United States Code, title 42, section 1382c(a), and would be eligible for medical assistance under the state plan if residing in a medical institution, and who requires a level of care provided in a hospital, skilled nursing facility, intermediate care facility, or intermediate care facility for persons with mental retardation or related conditions, for whom home care is appropriate, provided that the cost to medical assistance for home care services is not more than the amount that medical assistance would pay for appropriate institutional care.

(b) For purposes of this subdivision, "hospital" means an acute care institution as defined in section 144.696, subdivision 3, licensed pursuant to sections 144.50 to 144.58, which is appropriate if a person is technology dependent or has a chronic health condition which requires frequent intervention by a health care professional to avoid death.

(c) For purposes of this subdivision, "skilled nursing facility" and "intermediate care facility" means a facility which provides nursing care as defined in section 144A.01, subdivision 5, licensed pursuant to sections 144A.02 to 144A.10, which is appropriate if a person is in active restorative treatment; is in need of special treatments provided or supervised by a licensed nurse; or has unpredictable episodes of active disease processes requiring immediate judgment by a licensed nurse.

(d) For purposes of this subdivision, "intermediate care facility for the mentally retarded" or "ICF/MR" means a program licensed to provide services to persons with mental retardation under section 252.28, and chapter 245A, and a physical plant licensed as a supervised living facility under chapter 144, which together are certified by the Minnesota department of health as meeting the standards in Code of Federal Regulations, title 42, part 483, for an intermediate care facility which provides services for persons with mental retardation or persons with related conditions who require 24-hour supervision and active treatment for medical, behavioral, or habilitation needs.

(e) For purposes of this subdivision, a person "requires a level of care provided in a hospital, skilled nursing facility, intermediate care facility, or intermediate care facility for persons with mental retardation or related conditions" if the person requires 24-hour supervision because the person exhibits suicidal or homicidal ideation or behavior, psychosomatic disorders or somatopsychic disorders that may become life threatening, severe socially unacceptable behavior associated with psychiatric disorder, psychosis or severe developmental problems requiring continuous skilled observation, or disabling symptoms that do not respond to office-centered outpatient treatment.

The determination of the level of care needed by the child shall be made by the commissioner based on information supplied to the commissioner by the case manager if the child has one, the parent or guardian, the child's physician or physicians or, if available, the screening information obtained under section 256B.092.

History: *1991 c 292 art 4 s 33,34*

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

Subdivision 1. **Pregnant women and infants.** An infant less than one year of age or a pregnant woman who has written verification of a positive pregnancy test from a physician or licensed registered nurse, is eligible for medical assistance if countable family income is equal to or less than 185 percent of the federal poverty guideline for the same family size. Eligibility for a pregnant woman or infant less than one year of age under this subdivision must be determined without regard to asset standards established in section 256B.056, subdivision 3.

An infant born on or after January 1, 1991, to a woman who was eligible for and receiving medical assistance on the date of the child's birth shall continue to be eligible for medical assistance without redetermination until the child's first birthday, as long as the child remains in the woman's household.

Subd. 2. **Children.** A child one through five years of age in a family whose countable income is less than 133 percent of the federal poverty guidelines for the same family size, is eligible for medical assistance. A child six through 18 years of age, who was born after September 30, 1983, in a family whose countable income is less than 100 percent of the federal poverty guidelines for the same family size is eligible for medical assistance. Eligibility for children under this subdivision must be determined without regard to asset standards established in section 256B.056, subdivision 3.

Subd. 3. **Qualified Medicare beneficiaries.** A person who is entitled to Part A Medicare benefits, whose income is equal to or less than 85 percent of the federal poverty guidelines, and whose assets are no more than twice the asset limit used to determine eligibility for the supplemental security income program, 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. The income limit shall be increased to 90 percent of the federal poverty guidelines on January 1, 1990; and to 100 percent on January 1, 1991. 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 the first day of the second full month following publication of the change in the federal poverty guidelines.

Subd. 4. **Qualified working disabled adults.** A person who is entitled to Medicare Part A benefits under section 1818A of the Social Security Act; whose income does not exceed 200 percent of the federal poverty guidelines for the applicable family size; whose nonexempt assets do not exceed twice the maximum amount allowable under the supplemental security income program, according to family size; and who is not otherwise eligible for medical assistance, is eligible for medical assistance reimbursement of the Medicare Part A premium.

[For text of subd 5, see M.S.1990]

Subd. 6. **Disabled widows and widowers.** A person who is at least 50 years old who is entitled to disabled widow's or widower's benefits under United States Code, title 42, section 402(e) or (f), who is not entitled to Medicare Part A, and who received supplemental security income or Minnesota supplemental aid in the month before the month the widow's or widower's benefits began, is eligible for medical assistance as long as the person would be entitled to supplemental security income or Minnesota supplemental aid in the absence of the widow's or widower's benefits.

History: *1991 c 292 art 4 s 35-39*

256B.0575 AVAILABILITY OF INCOME FOR INSTITUTIONALIZED PERSONS.

When an institutionalized person is determined eligible for medical assistance, the income that exceeds the deductions in paragraphs (a) and (b) must be applied to the cost of institutional care.

(a) The following amounts must be deducted from the institutionalized person's income in the following order:

(1) the personal needs allowance under section 256B.35 or, for a veteran who does not have a spouse or child, the amount of any veteran's pension not exceeding $90 per month;

(2) the personal allowance for disabled individuals under section 256B.36;

(3) if the institutionalized person has a legally appointed guardian or conservator, five percent of the recipient's gross monthly income up to $100 as reimbursement for guardianship or conservatorship services;

(4) a monthly income allowance determined under section 256B.058, subdivision

2, but only to the extent income of the institutionalized spouse is made available to the community spouse;

(5) a monthly allowance for children under age 18 which, together with the net income of the children, would provide income equal to the medical assistance standard for families and children according to section 256B.056, subdivision 4, for a family size that includes only the minor children. This deduction applies only if the children do not live with the community spouse and only if the children resided with the institutionalized person immediately prior to admission;

(6) a monthly family allowance for other family members, equal to one-third of the difference between 122 percent of the federal poverty guidelines and the monthly income for that family member;

(7) reparations payments made by the Federal Republic of Germany; and

(8) amounts for reasonable expenses incurred for necessary medical or remedial care for the institutionalized spouse that are not medical assistance covered expenses and that are not subject to payment by a third party.

For purposes of clause (6), "other family member" means a person who resides with the community spouse and who is a minor or dependent child, dependent parent, or dependent sibling of either spouse. "Dependent" means a person who could be claimed as a dependent for federal income tax purposes under the Internal Revenue Code.

(b) Income shall be allocated to an institutionalized person for a period of up to three calendar months, in an amount equal to the medical assistance standard for a family size of one if:

(1) a physician certifies that the person is expected to reside in the long-term care facility for three calendar months or less;

(2) if the person has expenses of maintaining a residence in the community; and

(3) if one of the following circumstances apply:

(i) the person was not living together with a spouse or a family member as defined in paragraph (a) when the person entered a long-term care facility; or

(ii) the person and the person's spouse become institutionalized on the same date, in which case the allocation shall be applied to the income of one of the spouses.

For purposes of this paragraph, a person is determined to be residing in a licensed nursing home, regional treatment center, or medical institution if the person is expected to remain for a period of one full calendar month or more.

History: *1986 c 444; 1991 c 292 art 4 s 40*

256B.059 TREATMENT OF ASSETS WHEN A SPOUSE IS INSTITUTIONALIZED.

[For text of subds 1 to 3, see M.S.1990]

Subd. 4. **Increased community spouse asset allowance; when allowed.** (a) If either the institutionalized spouse or community spouse establishes that the community spouse asset allowance under subdivision 3 (in relation to the amount of income generated by such an allowance) is not sufficient to raise the community spouse's income to the minimum monthly maintenance needs allowance in section 256B.058, subdivision 2, paragraph (c), there shall be substituted for the amount allowed to be transferred an amount sufficient, when combined with the monthly income otherwise available to the spouse, to provide the minimum monthly maintenance needs allowance. A substitution under this paragraph may be made only if the assets of the couple have been arranged so that the maximum amount of income-producing assets, at the maximum rate of return, are available to the community spouse under the community spouse asset allowance. The maximum rate of return is the average rate of return available from the financial institution holding the asset, or a rate determined by the commissioner to be reasonable according to community standards, if the asset is not held by a financial institution.

(b) The community spouse asset allowance under subdivision 3 can be increased by court order or hearing that complies with the requirements of United States Code, title 42, section 1396r-5.

[For text of subd 5, see M.S.1990]

History: *1991 c 199 art 1 s 61*

256B.0625 COVERED SERVICES.

[For text of subd 1, see M.S.1990]

Subd. 2. **Skilled and intermediate nursing care.** Medical assistance covers skilled nursing home services and services of intermediate care facilities, including training and habilitation services, as defined in section 252.41, subdivision 3, for persons with mental retardation or related conditions who are residing in intermediate care facilities for persons with mental retardation or related conditions. Medical assistance must not be used to pay the costs of nursing care provided to a patient in a swing bed as defined in section 144.562, unless (a) the facility in which the swing bed is located is eligible as a sole community provider, as defined in Code of Federal Regulations, title 42, section 412.92, or the facility is a public hospital owned by a governmental entity with 15 or fewer licensed acute care beds; (b) the health care financing administration approves the necessary state plan amendments; (c) the patient was screened as provided by law; (d) the patient no longer requires acute care services; and (e) no nursing home beds are available within 25 miles of the facility. The daily medical assistance payment for nursing care for the patient in the swing bed is the statewide average medical assistance skilled nursing care per diem as computed annually by the commissioner on July 1 of each year.

[For text of subd 3, see M.S.1990]

Subd. 4. **Outpatient and physician-directed clinic services.** Medical assistance covers outpatient hospital or physician-directed clinic services. The physician-directed clinic staff shall include at least two physicians and all services shall be provided under the direct supervision of a physician. Hospital outpatient departments are subject to the same limitations and reimbursements as other enrolled vendors for all services, except initial triage, emergency services, and services not provided or immediately available in clinics, physicians' offices, or by other enrolled providers. "Emergency services" means those medical services required for the immediate diagnosis and treatment of medical conditions that, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death or are necessary to alleviate severe pain. Neither the hospital, its employees, nor any physician or dentist, shall be liable in any action arising out of a determination not to render emergency services or care if reasonable care is exercised in determining the condition of the person, or in determining the appropriateness of the facilities, or the qualifications and availability of personnel to render these services consistent with this section.

Subd. 4a. **Second medical opinion for surgery.** Certain surgeries require a second medical opinion to confirm the necessity of the procedure, in order for reimbursement to be made. The commissioner shall publish in the State Register a list of surgeries that require a second medical opinion and the criteria and standards for deciding whether a surgery should require a second medical opinion. The list and the criteria and standards are not subject to the requirements of sections 14.01 to 14.69. The commissioner's decision about whether a second medical opinion is required, made according to rules governing that decision, is not subject to administrative appeal.

[For text of subd 5, see M.S.1990]

Subd. 6. [Repealed, 1991 c 292 art 7 s 26]

Subd. 6a. **Home health services.** Home health services are those services specified in Minnesota Rules, part 9505.0290. Medical assistance covers home health services

at a recipient's home residence. Medical assistance does not cover home health services at a hospital, nursing facility, intermediate care facility, or a health care facility licensed by the commissioner of health, unless the commissioner of human services has prior authorized skilled nurse visits for less than 90 days for a resident at an intermediate care facility for persons with mental retardation, to prevent an admission to a hospital or nursing facility. Home health services must be provided by a Medicare certified home health agency. All nursing and home health aide services must be provided according to section 256B.0627.

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 and when, without the provision of private duty nursing, their health and safety would be jeopardized. Medical assistance does not cover private duty nursing services at 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. 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 spouse of the recipient or the parent or foster care provider of a recipient who is under age 18, or the recipient's legal guardian.

[For text of subds 8 to 12, see M.S.1990]

Subd. 13. **Drugs.** (a) Medical assistance covers drugs if prescribed by a licensed practitioner and dispensed by a licensed pharmacist, or by a physician enrolled in the medical assistance program as a dispensing physician. The commissioner 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 commissioner shall appoint the formulary committee members no later than 30 days following July 1, 1981. 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 two-year terms and shall serve without compensation. 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. Prior authorization may be required by the commissioner before certain formulary drugs are eligible for payment. The formulary shall not include: drugs or products for which there is no federal funding; over-the-counter drugs, except for antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, and vitamins for children under the age of seven and pregnant or nursing women; or 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, the administrative procedure act; nutritional products, except for those products needed for treatment of phenylketonuria, hyperlysinemia, maple syrup urine disease, a combined allergy to human milk, cow milk, and soy formula, or any other childhood or adult diseases, conditions, or disorders identified by the commissioner as requiring a similarly necessary nutritional product; anorectics; and drugs for which medical value has not been estab-

lished. Separate payment shall not be made for nutritional products for residents of long-term care facilities; payment for dietary requirements is a component of the per diem rate paid to these facilities. Payment to drug vendors shall not be modified before the formulary is established except that the commissioner shall not permit payment for any drugs which may not by law be included in the formulary, and the commissioner's determination shall not be subject to chapter 14, the administrative procedure act. The commissioner shall publish conditions for prohibiting payment for specific drugs after considering the formulary committee's recommendations.

(b) 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 established by the commissioner, 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. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. The actual acquisition cost of a drug may be estimated by the commissioner. 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. 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. Implementation of any change in the fixed dispensing fee that has not been subject to the administrative procedure act is limited to not more than 180 days, unless, during that time, the commissioner initiates rulemaking through the administrative procedure act.

[For text of subds 14 to 16, see M.S.1990]

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. The commissioner shall establish maximum medical assistance reimbursement rates for special transportation services for persons who need a wheelchair lift van or stretcher-equipped vehicle and for those who do not need a wheelchair lift van or stretcher-equipped vehicle. The average of these two rates must not exceed $12.50 for the base rate and $1 per mile. Special transportation provided to nonambulatory persons who do not need a wheelchair lift van or stretcher-equipped vehicle, may be reimbursed at a lower rate than special transportation provided to persons who need a wheelchair lift van or stretcher-equipped vehicle.

[For text of subd 18, see M.S.1990]

Subd. 19. [Repealed, 1991 c 292 art 7 s 26]

Subd. 19a. **Personal care services.** Medical assistance covers personal care services in a recipient's home. Recipients who can direct their own care, or persons who cannot direct their own care when accompanied by the responsible party, may use approved hours outside the home when normal life activities take them outside the home and when, without the provision of personal care, their health and safety would be jeopardized. Medical assistance does not cover personal care services at 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. Total hours of service and payment allowed for services outside the home cannot exceed that which is otherwise allowed for personal care services in an in-home setting according to section 256B.0627. All personal care services must be provided according to section 256B.0627. Personal care services may not be reimbursed if the personal care assistant is the spouse of the recipient or the parent of a recipient under age 18, the responsible party, the foster care provider of a recipient who cannot direct their own care or the recipient's legal guardian. Parents of adult recipients, adult children of the recipient or adult siblings of the recipient may be reimbursed for personal care services if they are granted a waiver under section 256B.0627. An exception for foster care providers may be made according to section 256B.0627, subdivision 5, paragraph (j).

Subd. 20. **Mental illness case management.** To the extent authorized by rule of the state agency, medical assistance covers case management services to persons with serious and persistent mental illness or subject to federal approval, children with severe emotional disturbance.

[For text of subds 22 and 23, see M.S.1990]

Subd. 24. **Other medical or remedial care.** Medical assistance covers any other medical or remedial care licensed and recognized under state law unless otherwise prohibited by law, except licensed chemical dependency treatment programs or primary treatment or extended care treatment units in hospitals that are covered under chapter 254B. The commissioner shall include chemical dependency services in the state medical assistance plan for federal reporting purposes, but payment must be made under chapter 254B. The commissioner shall publish in the State Register a list of elective surgeries that require a second medical opinion before medical assistance reimbursement, and the criteria and standards for deciding whether an elective surgery should require a second medical opinion. The list and criteria and standards are not subject to the requirements of sections 14.01 to 14.69.

Subd. 25. **Prior authorization required.** The commissioner shall publish in the State Register a list of health services that require prior authorization, as well as the criteria and standards used to select health services on the list. The list and the criteria and standards used to formulate it are not subject to the requirements of sections 14.001 to 14.69. The commissioner's decision whether prior authorization is required for a health service is not subject to administrative appeal.

[For text of subds 26 and 27, see M.S.1990]

Subd. 28. **Certified nurse practitioner services.** Medical assistance covers services performed by a certified pediatric nurse practitioner, a certified family nurse practitioner, a certified adult nurse practitioner, or a certified geriatric nurse practitioner in independent practice, if the services are otherwise covered under this chapter as a physician service, and if the service is within the scope of practice of the nurse practitioner's license as a registered nurse, as defined in section 148.171.

[For text of subd 29, see M.S.1990]

Subd. 30. **Other clinic services.** (a) Medical assistance covers rural health clinic ser-

vices, 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.

History: *1991 c 292 art 4 s 41-44,46-49; art 6 s 45; art 7 s 5,9-11*

NOTE: Subdivision 19 was also amended by Laws 1991, chapter 292, article 4, section 45, to read as follows:

"Subd. 19. **Personal care assistants.** Medical assistance covers personal care assistant services provided by an individual, not a relative, who is qualified to provide the services, where the services are prescribed by a physician in accordance with a plan of treatment and are supervised by a registered nurse. Payments to personal care assistants shall be adjusted annually to reflect changes in the cost of living or of providing services by the average annual adjustment granted to vendors such as nursing homes and home health agencies. The commissioner shall not provide an annual inflation adjustment for the fiscal year ending June 30, 1993."

256B.0627 COVERED SERVICE; HOME CARE SERVICES.

Subdivision 1. **Definition.** "Home care services" means a health service, determined by the commissioner as medically necessary, that is ordered by a physician and documented in a care 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. "Medically necessary" has the meaning given in Minnesota Rules, parts 9505.0170 to 9505.0475. "Care plan" means a written description of the services needed which shall include a detailed description of the covered home care services, who is providing the services, frequency of those services, and duration of those services. The care plan shall also include expected outcomes and goals including expected date of goal accomplishment.

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 aide services under section 256B.0625, subdivision 6a;

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

(5) nursing supervision of personal care services under section 256B.0625, subdivision 19a.

Subd. 3. [Repealed, 1991 c 292 art 7 s 26]

Subd. 4. **Personal care services.** (a) The personal care services that are eligible for payment are the following:

(1) bowel and bladder care;

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

(3) range of motion exercises;

(4) respiratory assistance;

(5) transfers;

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

(7) turning and positioning;

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

(9) application and maintenance of prosthetics and orthotics;

(10) cleaning medical equipment;

(11) dressing or undressing;

(12) assistance with food, nutrition, and diet activities;

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

(14) helping the recipient to complete daily living skills such as personal and oral hygiene and medication schedules;

(15) supervision and observation that are medically necessary because of the recipient's diagnosis or disability; and

(16) incidental household services that are an integral part of a personal care service described in clauses (1) to (15).

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

(1) personal care services that are not in the care plan developed by the supervising registered nurse in consultation with the personal care assistants and the recipient or the responsible party directing the care of the recipient;

(2) services that are not supervised by the registered nurse;

(3) services provided bv the recipient's spouse, legal guardian, or parent of a minor child;

(4) foster care provider of a recipient who cannot direct their own care, unless prior authorized by the commissioner under paragraph (j);

(5) sterile procedures;

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

(7) services provided by parents of adult recipients, adult children, or adult siblings, 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, the relative is needed in order to provide an adequate number of qualified personal care assistants to meet the medical needs of the recipient;

(8) homemaker services that are not an integral part of a personal care services; and

(9) home maintenance, or chore services.

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

(a) **Exemption from payment limitations.** The level, or the number of hours or visits of a specific service, of home care services to a recipient that began before and is continued without increase on or after December 1987, shall be exempt from the payment limitations of this section, as long as the services are medically necessary.

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

(1) a total of 40 home health aide visits, skilled nurse visits, health promotions, or health assessments under section 256B.0625, subdivision 6a; and

(2) a total of ten hours of nursing supervision under section 256B.0625, subdivision 7 or 19a.

(c) **Prior authorization; exceptions.** All home care services above the limits in paragraph (b) 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; or

(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.

(d) **Retroactive authorization.** A request for retroactive authorization under paragraph (c) will be evaluated according to the same criteria applied to prior authorization requests. Implementation of this provision shall begin no later than October 1, 1991, except that recipients who are currently receiving medically necessary services above the limits established under this subdivision may have a reasonable amount of time to arrange for waivered services under section 256B.49 or to establish an alternative living arrangement. All current recipients shall be phased down to the limits established under paragraph (b) on or before April 1, 1992.

(e) **Assessment and care plan.** The home care provider shall conduct an assessment and complete a care plan using forms specified by the commissioner. For the recipient to receive, or continue to receive, home care services, the provider must submit evidence necessary for the commissioner to determine the medical necessity of the home care services. The provider shall submit to the commissioner the assessment, the care 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.

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

(1) **Home health services.** All home health services provided by a nurse or a home health aide that exceed the limits established in paragraph (b) must be prior authorized by the commissioner or the commissioner's designee. Prior authorization must be based on medical necessity and cost-effectiveness when compared with other care options.

(2) **Personal care services.** (i) All personal care services must be prior authorized by the commissioner or the commissioner's designee except for the limits on supervision established in paragraph (b). The amount of personal care services authorized must be based on the recipient's case mix classification according to section 256B.0911, except that 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 case mix level;

(B) up to three times the average number of direct care hours provided in nursing facilities for recipients who have complex medical needs;

(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 complex behaviors;

(D) up to the amount the commissioner would pay, as of July 1, 1991, 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.091 or 256B.092.

(ii) The number of direct care hours shall be determined according to annual cost reports which are submitted to the department by nursing facilities each year. The average number of direct care hours, as established by May 1, shall be incorporated into the home care limits on July 1 each year.

(iii) The case mix level shall be determined by the commissioner or the commissioner's designee based on information submitted to the commissioner by the personal care provider on forms specified by the commissioner. The forms 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 children and nonelderly adults who need home care. The commissioner shall establish these forms and protocols under this section and shall use the advisory group established in section 256B.04, subdivision 16, for consultation in establishing the forms and protocols by October 1, 1991.

(iv) A recipient shall qualify as having complex medical needs if they require:

(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; or

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

(v) A recipient shall qualify as having complex behavior if the recipient exhibits on a daily basis the following:

(A) self-injurious behavior;

(B) unusual or repetitive habits;

(C) withdrawal behavior;

(D) hurtful behavior to others;

(E) socially or offensive behavior;

(F) destruction of property; or

(G) a need for constant one-to-one supervision for self-preservation.

(vi) The complex behaviors in clauses (A) to (G) have the meanings developed under section 256B.501.

(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 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 up to 16 hours per day of private duty nursing services or up to 24 hours per day of private duty nursing services until such time as the commissioner is able to make a determination of eligibility for recipients who are applying for home care services under the community alternative care program developed under section 256B.49, or until it is determined that a health benefit plan is required to pay for medically necessary nursing services. 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.

(g) **Prior authorization; time limits.** The commissioner or the commissioner's designee shall determine the time period for which a prior authorization shall remain valid. 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 through the process described above. Under no circumstances shall a prior authorization be valid for more than 12 months.

(h) **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, and the amount, scope, and duration of home care services reimbursable by medical assistance, based on the assessment, the care plan, the recipient's age, the recipient's medical condition, and diagnosis or disability. The commissioner may publish additional criteria for determining medical necessity according to section 256B.04.

(i) **Prior authorization requests; temporary services.** The department has 30 days from receipt of the request to complete the prior authorization, during which time it may approve a temporary level of home care service. Authorization under this authority for a temporary level of home care services is limited to the time specified by the commissioner.

(j) **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 (b).

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 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 the recipient is referred to the commissioner by a regional treatment center preadmission evaluation team;

(3) personal care 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 the recipient is referred to the commissioner by a regional treatment center preadmission evaluation team;

(4) home care services when the number of foster care residents is greater than four; or

(5) home care services when combined with foster care payments, less the base rate, that exceed the total amount that public funds would pay for the recipient's care in a medical institution.

Subd. 6. **Recovery of excessive payments.** The commissioner shall seek monetary recovery from providers of payments made for services which exceed the limits established in this section.

History: *1991 c 292 art 7 s 12*

256B.0628 PRIOR AUTHORIZATION AND REVIEW OF HOME CARE SERVICES.

Subdivision 1. **State coordination.** The commissioner shall supervise the coordination of the prior authorization and review of home care services that are reimbursed by medical assistance.

Subd. 2. **Contractor duties.** (a) The commissioner may contract with qualified registered nurses, or qualified agencies, to provide home care prior authorization and review services for medical assistance recipients who are receiving home care services.

(b) Reimbursement for the prior authorization function shall be made through the medical assistance administrative authority. The state shall pay the nonfederal share. The contractor must:

(1) assess the recipient's individual need for services required to be cared for safely in the community;

(2) ensure that a care plan that meets the recipient's needs is developed by the appropriate agency or individual;

(3) ensure cost-effectiveness of medical assistance home care services;

(4) recommend to the commissioner the approval or denial of the use of medical assistance funds to pay for home care services when home care services exceed thresholds established by the commissioner under Minnesota Rules, parts 9505.0170 to 9505.0475;

(5) reassess the recipient's need for and level of home care services at a frequency determined by the commissioner; and

(6) conduct on-site assessments when determined necessary by the commissioner.

(c) In addition, the contractor may be requested by the commissioner to:

(1) review care plans and reimbursement data for utilization of services that exceed community-based standards for home care, inappropriate home care services, home care services that do not meet quality of care standards, or unauthorized services and make appropriate referrals to the commissioner or other appropriate entities based on the findings;

(2) assist the recipient in obtaining services necessary to allow the recipient to remain safely in or return to the community;

(3) coordinate home care services with other medical assistance services under section 256B.0625;

(4) assist the recipient with problems related to the provision of home care services; and

(5) assure the quality of home care services.

(d) For the purposes of this section, "home care services" means medical assistance services defined under section 256B.0625, subdivisions 6a, 7, and 19a.

History: *1991 c 292 art 7 s 13*

256B.064 INELIGIBLE PROVIDER.

[For text of subds 1 to 1c, see M.S.1990]

Subd. 2. The commissioner shall determine monetary amounts to be recovered and the sanction to be imposed upon a vendor of medical care for conduct described by subdivision 1a. Neither a monetary recovery nor a sanction will be sought by the commissioner without prior notice and an opportunity for a hearing, pursuant to chapter 14, on the commissioner's proposed action, provided that the commissioner may

suspend or reduce payment to a vendor of medical care, except a nursing home or convalescent care facility, prior to the hearing if in the commissioner's opinion that action is necessary to protect the public welfare and the interests of the program.

Upon receipt of a notice that a monetary recovery or sanction is to be imposed, a vendor may request a contested case, as defined in section 14.02, subdivision 3, by filing with the commissioner a written request of appeal. The appeal request must be received by the commissioner no later than 30 days after the date the notification of monetary recovery or sanction was mailed to the vendor. The appeal request must specify:

(1) each disputed item, the reason for the dispute, and an estimate of the dollar amount involved for each disputed item;

(2) the computation that the vendor believes is correct;

(3) the authority in statute or rule upon which the vendor relies for each disputed item;

(4) the name and address of the person or entity with whom contacts may be made regarding the appeal; and

(5) other information required by the commissioner.

History: *1991 c 292 art 5 s 29*

256B.0641 RECOVERY OF OVERPAYMENTS.

[For text of subds 1 and 2, see M.S.1990]

Subd. 3. **Facility in receivership.** Subdivision 2 does not apply to the change of ownership of a facility to a nonrelated organization while the facility to be sold, transferred or reorganized is in receivership under section 245A.12 or 245A.13, and the commissioner during the receivership has not determined the need to place residents of the facility into a newly constructed or newly established facility. Nothing in this subdivision limits the liability of a former owner.

History: *1991 c 292 art 6 s 46*

256B.08 APPLICATION.

[For text of subds 1 and 2, see M.S.1990]

Subd. 3. **Outreach locations.** The local agency must establish locations, other than those used to process applications for cash assistance, to receive and perform initial processing of applications for pregnant women and children who want medical assistance only. At a minimum, these locations must be in federally qualified health centers and in hospitals that receive disproportionate share adjustments under section 256.969, subdivision 8, except that hospitals located outside of this state that receive the disproportionate share adjustment are not included. Initial processing of the application need not include a final determination of eligibility. Local agencies shall designate a person or persons within the agency who will receive the applications taken at an outreach location and the local agency will be responsible for timely determination of eligibility.

History: *1991 c 292 art 4 s 50*

256B.091 [Repealed, 1991 c 292 art 7 s 26]

256B.0911 NURSING HOME PREADMISSION SCREENING.

Subdivision 1. **Purpose and goal.** The purpose of the preadmission screening program is to prevent or delay certified nursing facility placements by assessing applicants and residents and offering cost-effective alternatives appropriate for the person's needs. Further, the goal of the program 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.

Subd. 2. **Persons required to be screened; exemptions.** All applicants to Medicaid certified nursing facilities must be screened prior to admission, regardless of income, assets, or funding sources, except the following:

(1) patients who, having entered acute care facilities from certified nursing facilities, are returning to a certified nursing facility;

(2) residents transferred from other certified nursing facilities;

(3) individuals whose length of stay is expected to be 30 days or less based on a physician's certification, if the facility notifies the screening team prior to admission and provides an update to the screening team on the 30th day after admission;

(4) individuals who have a contractual right to have their nursing facility care paid for indefinitely by the veteran's administration; or

(5) individuals who are enrolled in the Ebenezer/Group Health social health maintenance organization project at the time of application to a nursing home; or

(6) individuals who are screened by another state within three months before admission to a certified nursing facility.

Regardless of the exemptions in clauses (2) to (6), persons who have a diagnosis or possible diagnosis of mental illness, mental retardation, or a related condition must be screened before admission 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 101-508.

Persons transferred from an acute care facility to a certified nursing facility may be admitted to the nursing facility before screening, if authorized by the county agency; however, the person must be screened within ten working days after the admission.

Other persons who are not applicants to nursing facilities must be screened if a request is made for a screening.

Subd. 3. **Persons responsible for conducting the preadmission screening.** (a) A local screening team shall be established by the county agency and the county public health nursing service of the local board of health. Each local screening team shall be composed of a social worker and a public health nurse from their respective county agencies. Two or more counties may collaborate to establish a joint local screening team or teams.

(b) Both members of the team must conduct the screening. However, individuals who are being transferred from an acute care facility to a certified nursing facility may be screened by only one member of the screening team in consultation with the other member.

(c) In assessing a person's needs, each screening team shall have a physician available for consultation and shall consider the assessment of the individual's attending physician, if any. The individual's physician shall be included on the screening team if the physician chooses to participate. Other personnel may be included on the team as deemed appropriate by the county agencies.

(d) If a person who has been screened must be reassessed to assign a case mix classification because admission to a nursing facility occurs later than the time allowed by rule following the initial screening and assessment, the reassessment may be completed by the public health nurse member of the screening team.

Subd. 4. **Responsibilities of the county agency and the screening team.** (a) The county agency shall:

(1) provide information and education to the general public regarding availability of the preadmission screening program;

(2) accept referrals from individuals, families, human service and health professionals, and hospital and nursing facility personnel;

(3) assess the health, psychological, and social needs of referred individuals and identify services needed to maintain these persons in the least restrictive environments;

(4) determine if the individual screened needs nursing facility level of care;

(5) assess active treatment needs in cooperation with:

(i) a qualified mental health professional for persons with a primary or secondary diagnosis of mental illness; and

(ii) a qualified mental retardation professional for persons with a primary or secondary diagnosis of mental retardation or related conditions. For purposes of this clause, a qualified mental retardation professional must meet the standards for a qualified mental retardation professional in Code of Federal Regulations, title 42, section 483.430;

(6) make recommendations for individuals screened regarding cost-effective community services which are available to the individual;

(7) make recommendations for individuals screened regarding nursing home placement when there are no cost-effective community services available;

(8) develop an individual's community care plan and provide follow-up services as needed; and

(9) prepare and submit reports that may be required by the commissioner of human services.

The county agency may determine in cooperation with the local board of health that the public health nursing agency of the local board of health is the lead agency which is responsible for all of the activities above except clause (5).

(b) The screening team shall document that the most cost-effective alternatives available were offered to the individual or the individual's legal representative. For purposes of this section, "cost-effective alternatives" means community services and living arrangements that cost the same or less than nursing facility care.

The screening shall be conducted within ten working days after the date of referral or, for those approved for transfer from an acute care facility to a certified nursing facility, within ten working days after admission to the nursing facility. For persons who are eligible for medical assistance or who would be eligible within 180 days of admission to a nursing facility and who are admitted to a nursing facility, the nursing facility must include the screening team or the case manager in the discharge planning process for those individuals who the team has determined have discharge potential. The screening team or the case manager must ensure a smooth transition and follow-up for the individual's return to the community.

Local screening teams shall cooperate with other public and private agencies in the community, in order to offer a variety of cost-effective services to the disabled and elderly. The screening team shall encourage the use of volunteers from families, religious organizations, social clubs, and similar civic and service organizations to provide services.

Subd. 5. **Simplification of forms.** The commissioner shall minimize the number of forms required in the preadmission screening process and shall limit the screening document to items necessary for care plan approval, reimbursement, program planning, evaluation, and policy development.

Subd. 6. **Reimbursement for preadmission screening.** (a) The total screening cost 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 estimate of the total annual cost of screenings allowed in the county for the following rate year by 12 to determine the monthly cost estimate and allocating the monthly cost estimate to each nursing facility based on the number of licensed beds in the nursing facility.

(b) The rate allowed for a screening where two team members are present shall be the actual costs up to $195. The rate allowed for a screening where only one team member is present shall be the actual costs up to $117. Annually on July 1, the commissioner shall adjust the rate up to the percentage change forecast in the fourth quarter of the prior calendar year by the Home Health Agency Market Basket of Operating Costs,

unless otherwise adjusted by statute. The Home Health Agency Market Basket of Operating Costs is published by Data Resources, Inc.

(c) The monthly cost estimate for each certified nursing facility must be submitted to the state by the county no later than February 15 of each year for inclusion in the nursing facility's payment rate on the following rate year. The commissioner shall include the reported annual estimated cost of screenings for each nursing facility as an operating cost of that nursing facility in accordance with section 256B.431, subdivision 2b, paragraph (g). The monthly cost estimates approved by the commissioner must be sent to the nursing facility by the county no later than April 15 of each year.

(d) If in more than ten percent of the total number of screenings performed by a county in a fiscal year for all individuals regardless of payment source, the screening timelines were not met because a county was late in screening the individual, the county is solely responsible for paying the cost of those delayed screenings that exceed ten percent.

(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 screening teams.

Subd. 7. **Reimbursement for certified nursing facilities.** Medical assistance reimbursement for nursing facilities shall be authorized for a medical assistance recipient only if a preadmission screening has been conducted or the local county agency has authorized an exemption. Medical assistance reimbursement for nursing facilities shall not be provided for any recipient who the local screening team has determined does not meet the level of care criteria for nursing facility placement.

An individual has a choice and makes the final decision between nursing facility placement and community placement after the screening team's recommendation. However, the local county mental health authority or the local 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 does need active treatment as defined in Public Law Numbers 100-203 and 101-508.

Appeals from the screening team's recommendation or the county agency's final decision shall be made according to section 256.045, subdivision 3.

Subd. 8. **Advisory committee.** The commissioner shall appoint an advisory committee to advise the commissioner on the preadmission screening program, the alternative care program under section 256B.0913, and the home- and community-based services waiver programs for the elderly and the disabled. The advisory committee shall review policies and procedures and provide advice and technical assistance to the commissioner regarding the effectiveness and the efficient administration of the programs. The advisory committee must consist of not more than 20 people appointed by the commissioner and must be comprised of representatives from public agencies, public and private service providers, and consumers from all areas of the state. Members of the advisory committee must not be compensated for service.

History: *1991 c 292 art 7 s 14*

256B.0913 ALTERNATIVE CARE PROGRAM.

Subdivision 1. **Purpose and goals.** The purpose of the alternative care program is to provide funding for or access to home and community-based services for frail elderly persons, in order to limit nursing facility placements. The program is designed to support frail 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 frail elderly people. Further, the goals of the program are:

(1) to contain medical assistance expenditures by providing care in the community at a cost the same or less than nursing facility costs; and

(2) to maintain the moratorium on new construction of nursing home beds.

Subd. 2. **Eligibility for services.** Alternative care services are available to all frail older Minnesotans. This includes:

(1) persons who are receiving medical assistance and served under the medical assistance program or the Medicaid waiver program;

(2) persons who would be eligible for medical assistance within 180 days of admission to a nursing facility and served under subdivisions 4 to 13; and

(3) persons who are paying for their services out-of-pocket.

Subd. 3. **Eligibility for funding for services for medical assistance recipients.** Funding for services for persons who are eligible for medical assistance is available under section 256B.0627, governing home care services, or 256B.0915, governing the Medicaid waiver for home- and community-based services.

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 screened by the county screening team or, if previously screened and served under the alternative care program, assessed by the local county social worker or public health nurse;

(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 screening team would recommend nursing facility admission or continued stay for the person if alternative care services were not available;

(5) the person needs services that are not available at that time in the county through other county, state, or federal funding sources; 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 average monthly medical assistance payment for nursing facility care at the individual's case mix classification to which the individual would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059.

(b) Individuals who meet the criteria in paragraph (a) and who have been approved for alternative care funding are called 180-day eligible clients.

(c) The statewide average payment for nursing facility care is the statewide average monthly nursing facility rate in effect on July 1 of the fiscal year in which the cost is incurred, less the statewide average monthly income of nursing facility residents who are age 65 or older and who are medical assistance recipients in the month of March of the previous fiscal year. This monthly limit does not prohibit the 180-day eligible client from paying for additional services needed or desired.

(d) In determining the total costs of alternative care services for one month, the costs of all services funded by the alternative care program, including supplies and equipment, must be included.

(e) 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 spend-down if the person applied, unless authorized by the commissioner.

(f) Alternative care funding is not available for a person who resides in a licensed nursing home or boarding care home, except for case management services which are being provided in support of the discharge planning process.

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; and

(9) care-related supplies and equipment.

(b) The county agency may use up to ten percent of the annual allocation of alternative care funding for payment of costs of meals delivered to the home, transportation, skilled nursing, chore services, companion services, nutrition services, and training for direct informal caregivers. The commissioner shall determine the impact on alternative care costs of allowing these additional services to be provided and shall report the findings to the legislature by February 15, 1993, including any recommendations regarding provision of the additional services.

(c) The county agency must ensure that the funds are used only to supplement and not supplant services available through other public assistance or services programs.

(d) These services must be provided by a licensed provider, a home health agency certified for reimbursement under Titles XVIII and XIX of the Social Security Act, or by persons or agencies employed by or contracted with the county agency or the public health nursing agency of the local board of health.

(e) The adult foster care rate shall be considered a difficulty of care payment and shall not include room and board.

(f) Personal care services may be provided by a personal care provider organization. A county agency may contract with a relative of the client to provide personal care services, but must ensure nursing supervision. Covered personal care services defined in section 256B.0627, subdivision 4, must meet applicable standards in Minnesota Rules, part 9505.0335.

(g) Costs for supplies and equipment that exceed $150 per item per month must have prior approval from the commissioner.

(h) For the purposes of this section, "assisted living" refers to supportive services provided by a single vendor to two or more alternative care grant clients who reside in the same apartment building of ten or more units. These services may include care coordination, the costs of preparing one or more nutritionally balanced meals per day, general oversight, and other supportive services which the vendor is licensed to provide according to sections 144A.43 to 144A.49, and which would otherwise be available to individual alternative care grant clients. Reimbursement from the lead agency shall be made to the vendor as a monthly capitated rate negotiated with the county agency. The capitated rate shall not exceed the state share of the average monthly medical assistance nursing facility payment rate of the case mix resident class to which the 180-day eligible client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059. The capitated rate may not cover rent and direct food costs. A person's eligibility to reside in the building must not be contingent on the person's acceptance or use of the assisted living services. Assisted living services as defined in this section shall not be authorized in boarding and lodging establishments licensed according to sections 157.01 to 157.031.

(i) For purposes of this section, companion services are defined as nonmedical care, supervision and oversight, provided to a functionally impaired adult. Companions may assist the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on medical care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the recipient. This service must be approved by the case manager as part of the care plan. Companion services must be provided by individuals or nonprofit organizations who are under contract with the local agency to provide the service. Any person related to the waiver recipient by blood, marriage or adoption cannot be reimbursed under this service. Persons providing companion services will be monitored by the case manager.

(j) For purposes of this section, training for direct informal caregivers is defined as a classroom or home course of instruction which may include: transfer and lifting

skills, nutrition, personal and physical cares, home safety in a home environment, stress reduction and management, behavioral management, long-term care decision making, care coordination and family dynamics. The training is provided to an informal unpaid caregiver of a 180-day eligible client which enables the caregiver to deliver care in a home setting with high levels of quality. The training must be approved by the case manager as part of the individual care plan. Individuals, agencies, and educational facilities which provide caregiver training and education will be monitored by the case manager.

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.

Subd. 7. **Case management.** The lead agency shall appoint a social worker from the county agency or a registered nurse from the county public health nursing service of the local board of health to be the case manager for any person receiving services funded by the alternative care program. The case manager must ensure the health and safety of the individual client and is responsible for the cost effectiveness of the alternative care individual care plan.

Subd. 8. **Requirements for individual care plan.** The case manager shall implement the plan of care for each 180-day eligible client and ensure that a client's service needs and eligibility are reassessed at least every six 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 to the commissioner verifying that the individual's alternative care is not available at that time through any other public assistance or service program. The lead agency shall provide documentation in each individual's plan of care and 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.

Subd. 9. **Contracting provisions for providers.** The lead agency shall document to the commissioner that the agency made reasonable efforts to inform potential providers of the anticipated need for services under the alternative care program, including a minimum of 14 days' written advance notice of the opportunity to be selected as a service provider and an annual public meeting with providers to explain and review the criteria for selection. The lead agency shall also document to the commissioner that the agency allowed potential providers an opportunity to be selected to contract with the county agency. Funds reimbursed to counties under this subdivision 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. The county shall provide a written statement of the reasons for not selecting providers.

Subd. 10. **Allocation formula.** (a) The alternative care appropriation for fiscal years 1992 and beyond shall cover only 180-day eligible clients.

(b) 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. The allocation for fiscal year 1992 shall be calculated using a base that is adjusted to exclude the medical assistance share of alternative care expenditures. The adjusted base is calculated by multiplying each county's allocation for fiscal year 1991 by the percentage of county alternative care expenditures for 180-day eligible clients. The percentage is determined based on expenditures for services rendered in fiscal year 1989 or calendar year 1989, whichever is greater.

(c) If the county expenditures for 180-day eligible clients are 95 percent or more of its 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 county expenditures for 180-day eligible clients are less than 95 percent of its 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) For fiscal year 1992 only, a county may receive an increased allocation if annualized service costs for the month of May 1991 for 180-day eligible clients are greater than the allocation otherwise determined. A county may apply for this increase by reporting projected expenditures for May to the commissioner by June 1, 1991. The amount of the allocation may exceed the amount calculated in paragraph (b). The projected expenditures for May must be based on actual 180-day eligible client caseload and the individual cost of clients' care plans. If a county does not report its expenditures for May, the amount in paragraph (c) or (d) shall be used.

(f) Calculations for paragraphs (c) and (d) are to be made as follows: for each county, the determination of 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 by June 1 of that year.

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 grant 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 by June 1 each year, for county agencies to apply for targeted funds. The counties selected for targeted funds shall be notified of the amount of their additional funding by August 1 of each year. 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.

(f) The allocation for each year after fiscal year 1992 shall be determined using the previous fiscal year's allocation, including any targeted funds, as the base and then applying the criteria under subdivision 10, paragraphs (c), (d), and (f), to the current year's expenditures.

Subd. 12. **Client premiums.** (a) A premium is required for all 180-day eligible clients to help pay for the cost of participating in the program.

(b) The county agency must collect the premium from the client and forward the amounts collected to the commissioner in the manner and at the times prescribed by the commissioner. 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. If a client fails or refuses to pay the premium due, 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.

(c) The commissioner shall establish a premium schedule ranging from $25 to $75 per month based on the client's income and assets. The schedule is not subject to chapter 14, but the commissioner shall publish the schedule and any later changes in the State Register and allow a period of 20 working days from the publication date for interested persons to comment before adopting the schedule in final form. 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. Emergency or permanent rules governing client premiums supersede any schedule adopted under the exemption from chapter 14 in this section.

Subd. 13. **County alternative care biennial plan.** The commissioner shall establish by rule, in accordance with chapter 14, procedures for the submittal and approval of a biennial county plan for the administration of the alternative care program and the coordination with other planning processes for the older adult. In addition to the procedures in rule, this county biennial plan shall also include:

(1) information on the administration of the preadmission screening program;

(2) information on the administration of the home and community-based services waivers for the elderly under section 256B.0915, and for the disabled under section 256.49;

(3) an application for targeted funds under subdivision 11; and

(4) an optional notice of intent to apply to participate in the long-term care projects under section 256B.0917.

Subd. 14. **Reimbursement and rate adjustments.** (a) Reimbursement for expenditures for the alternative care services shall be through the invoice processing procedures of the department's Medicaid management information system (MMIS), only with the approval of the client's case manager. To receive reimbursement, the county or vendor must submit invoices within 120 days following the month of service. The county agency and its vendors under contract shall not be reimbursed for services which exceed the county allocation.

(b) If a county collects less than 50 percent of the client premiums due under subdivision 12, the commissioner may withhold up to three percent of the county's final alternative care program allocation determined under subdivisions 10 and 11.

(c) Beginning July 1, 1991, the state will reimburse counties, up to the limits of state appropriations, 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 would be eligible for medical assistance within 180 days of admission to a nursing home.

(d) Annually on July 1, the commissioner must adjust the rates allowed for alternative care services by the forecasted percentage change in the Home Health Agency Market Basket of Operating Costs, for the fiscal year beginning July 1, compared to the previous fiscal year, unless otherwise adjusted by statute. The Home Health Agency Market Basket of Operating Costs is published by Data Resources, Inc. The forecast to be used is the one published for the calendar quarter beginning January 1, six months prior to the beginning of the fiscal year for which rates are set.

History: *1991 c 292 art 7 s 15*

256B.0915 MEDICAID WAIVER FOR HOME- AND COMMUNITY-BASED SERVICES.

Subdivision 1. **Authority.** The commissioner is authorized to apply for a home- and community-based services waiver for the elderly, authorized under section 1915(c) of the Social Security Act, in order to obtain federal financial participation to expand the availability of services for persons who are eligible for medical assistance. The commissioner may apply for additional waivers or pursue other federal financial participation which is advantageous to the state for funding home care services for the frail elderly who are eligible for medical assistance. The provision of waivered services to medical assistance recipients must comply with the criteria approved in the waiver.

Subd. 2. **Spousal impoverishment policies.** The commissioner shall seek to amend the federal waiver and the medical assistance state plan to allow spousal impoverishment criteria as authorized in Code of Federal Regulations, title 42, section 435.726(1924), and as implemented in sections 256B.0575, 256B.058, and 256B.059 to be applied to persons who are screened and determined to need a nursing facility level of care.

Subd. 3. **Limits of cases, rates, reimbursement, 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 waiver client shall be the statewide average payment rate of the case mix resident class to which the waiver client would be assigned under medical assistance case mix reimbursement system. The statewide average payment rate is calculated by determining the statewide average monthly nursing home rate effective July 1 of the fiscal year in which the cost is incurred, less the statewide average monthly income of nursing home residents who are age 65 or older, and who are medical assistance recipients in the month of March of the previous state fiscal year. 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

(2) cost of skilled nursing, home health aide, and personal care services reimbursable by medical assistance.

(c) Medical assistance funding for skilled nursing services, home health aide, and personal care services for waiver recipients must be approved by the case manager and included in the individual care plan.

(d) Expenditures for extended medical supplies and equipment that cost over $150 per month must have the commissioner's prior approval.

(e) Annually on July 1, the commissioner must adjust the rates allowed for services by the forecasted percentage change in the Home Health Agency Market Basket of Operating Costs, for the fiscal year beginning July 1, compared to the previous fiscal year, unless otherwise adjusted by statute. The Home Health Agency Market Basket of Operating Costs is published by Data Resources, Inc. The forecast to be used is the one published for the calendar quarter beginning January 1, six months prior to the beginning of the fiscal year for which rates are set.

(f) 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.

(g) 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.

History: *1991 c 292 art 7 s 16*

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 biennial 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 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 1992 and 1993 biennial plan is to implement at least four but not more than six projects in anticipation of a statewide program. These projects will begin 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.

This is done in conjunction with an expanded role of the interagency long-term care planning committee as described in section 144A.31. The services offered through these projects will be 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 establish 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 under a joint powers agreement, must establish a long-term care coordinating team consisting of county social service agencies, public health nursing service agencies, local boards of health, 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 under a joint powers agreement, 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 under a joint powers agreement, 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:

(1) 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.

(2) If only two projects are selected, at least one of them must be from a metropolitan statistical area as determined by the United States Census Bureau; if three or four

projects are selected, at least one but not more than two projects must be from a metropolitan statistical area; and if more than four projects are selected, at least two but not more than three projects must be from a metropolitan statistical area.

(3) Counties or groups of counties that submit a proposal for a project shall be assigned to types defined by institutional utilization rate and population growth rate in the following manner:

(i) Each county or group of counties shall be measured by the utilization rate of nursing homes and boarding care homes and by the projected growth rate of its population aged 85 and over between 1990 and 2000. For the purposes of this section, "utilization rate" means the proportion of the seniors aged 65 or older in the county or group of counties who reside in a licensed nursing home or boarding care home as determined by the most recent census of residents available from the department of health and the population estimates of the state demographer or the census, whichever is more recent. The "projected growth rate" is the rate of change in the county or group of counties of the population group aged 85 or older between 1990 and 2000 according to the projections of the state demographer.

(ii) The institutional utilization rate of a county or group of counties shall be converted to a category by assigning a "high utilization" category if the rate is above the median rate of all counties, and a "low utilization" category otherwise. The projected growth rate of a county or group of counties shall be converted to a category by assigning a score of "high growth" category if the rate is above the median rate of all counties, and a "low growth" category otherwise.

(iii) Types of areas shall be defined by the four combinations of the scores defined in item (ii): type 1 is low utilization - high growth, type 2 is high utilization - high growth, type 3 is high utilization - low growth, and type 4 is low utilization - low growth. Each county or group of counties making a proposal shall be assigned to one of these types.

(4) Projects shall be selected from each of the types in the order that the types are listed in paragraph (3), item (iii), with available funding allocated to projects until it is exhausted, with no more than 30 percent of available funding allocated to any one project. Available funding includes state administrative funds which have been appropriated for screening functions in subdivision 4, paragraph (b), clause (3), and for service developers and incentive grants in subdivision 5.

(5) If more than one county or group of counties within one of the types defined by paragraph (3) proposes a special project that meets all of the other conditions in paragraphs (1) and (2), the project that demonstrates the most cost-effective proposals in terms of the number of nursing home placements that can be expected to be diverted or converted to alternative care services per unit of cost shall be selected.

Subd. 3. **Local long-term care strategy.** The local long-term care strategy must list performance outcomes and indicators which meet the state's objectives. The local strategy must provide for:

(1) accessible information, assessment, and preadmission screening activities as described in subdivision 4;

(2) an application for expansion of alternative care targeted funds under section 256B.0913, for serving 180-day eligible clients, including those who are relocated from nursing homes;

(3) the development of additional services such as adult family foster care homes; family adult day care; assisted living projects and congregate housing service projects in apartment buildings; expanded home care services for evenings and weekends; expanded volunteer services; and caregiver support and respite care projects; and

(4) development and implementation of strategies for advocating, promoting, and developing long-term care insurance and encouraging insurance companies to offer long-term care insurance policies that are affordable and offer a wide range of benefits.

The county or groups of counties selected for the projects shall be required to comply with federal regulations, alternative care funding policies in section 256B.0913, and

the federal waiver programs' policies in section 256B.0915. The requirements for preadmission screening as defined in section 256B.0911, subdivisions 1 to 6, are waived for those counties selected as part of a long-term care strategy project. For persons who are eligible for medical assistance or who are 180-day eligible clients and who are screened after nursing facility admission, the nursing facility must include a screener in the discharge planning process for those individuals who the screener has determined have discharge potential. The agency responsible for the screening function in subdivision 4 must ensure a smooth transition and follow-up for the individual's return to the community. Requirements for an access, screening, and assessment function replace the preadmission screening requirements and are defined in subdivision 4. Requirements for the service development and service provision are defined in subdivision 5.

Subd. 4. **Accessible information, screening, and assessment function.** (a) The projects selected by and under contract with the commissioner shall establish an accessible information, screening, and assessment function for persons who need assistance and information regarding long-term care. This accessible information, screening, and assessment activity shall include information and referral, early intervention, follow-up contacts, telephone triage as defined in paragraph (f), home visits, assessments, preadmission screening, and relocation case management for the frail elderly and their caregivers in the area served by the county or counties. The purpose is to ensure that information and help is provided to elderly persons and their families in a timely fashion, when they are making decisions about long-term care. These functions may be split among various agencies, but must be coordinated by the local long-term care coordinating team.

(b) Accessible information, screening, and assessment functions shall be reimbursed as follows:

(1) The screenings of all persons entering nursing homes shall be reimbursed by the nursing homes in the counties of the project, through the same policy that is in place in fiscal year 1992 as established in section 256B.0911. The amount a nursing home pays to the county agency is that amount identified and approved in the February 15, 1991, estimated number of screenings and associated expenditures. This amount remains the same for fiscal year 1993;

(2) The level I screenings and the level II assessments required by Public Law Numbers 100-203 and 101-508 (OBRA) for persons with mental illness, mental retardation, or related conditions, are reimbursed through administrative funds with 75 percent federal funds and 25 percent state funds, as allowed by federal regulations and established in the contract; and

(3) Additional state administrative funds shall be available for the access, screening, and assessment activities that are not reimbursed under clauses (1) and (2). This amount shall not exceed the amount authorized in the guidelines and in instructions for the application and must be within the amount appropriated for this activity.

(c) The amounts available under paragraph (b) are available to the county or counties involved in the project to cover staff salaries and expenses to provide the services in this subdivision. The lead agency shall employ, or contract with other agencies to employ, within the limits of available funding, sufficient personnel to provide the services listed in this subdivision.

(d) Any information and referral functions funded by other sources, such as Title III of the Older Americans Act and Title XX of the Social Security Act and the Community Social Services Act, shall be considered by the local long-term care coordinating team in establishing this function to avoid duplication and to ensure access to information for persons needing help and information regarding long-term care.

(e) The staffing for the screening and assessment function must include, but is not limited to, a county social worker and a county public health nurse. The social worker and public health nurse are responsible for all assessments that are required to be completed by a professional. However, only one of these professionals is required to be present for the assessment.

(f) All persons entering a Medicaid certified nursing home or boarding care home must be screened through an assessment process, although the decision to conduct a face-to-face interview is left with the county social worker and the county public health nurse. All applicants to nursing homes must be screened and approved for admission by the county social worker or the county public health nurse named by the lead agency or the agencies which are under contract with the lead agency to manage the access, screening, and assessment functions. For applicants who have a diagnosis of mental illness, mental retardation, or a related condition, and are subject to the provisions of Public Law Numbers 100-203 and 101-508, their admission must be approved by the local mental health authority or the local developmental disabilities case manager.

The commissioner shall develop instructions and assessment forms for telephone triage and on-site screenings to ensure that federal regulations and waiver provisions are met.

For purposes of this section, the term "telephone triage" refers to a telephone or face-to-face consultation between health care and social service professionals during which the clients' circumstances are reviewed and the county agency professional sorts the individual into categories: (1) needs no screening, (2) needs an immediate screening, or (3) needs a screening after admission to a nursing home or after a return home. The county agency professional shall authorize admission to a nursing home according to the provisions in section 256B.0911, subdivision 7.

(g) The requirements for case mix assessments by a preadmission screening team may be waived and the nursing home shall complete the case mix assessments which are not conducted by the county public health nurse according to the procedures established under Minnesota Rules, part 9549.0059. The appropriate county or the lead agency is responsible for distributing the quality assurance and review form for all new applicants to nursing homes.

(h) The lead agency or the agencies under contract with the lead agency which are responsible for the accessible information, screening, and assessment function must complete the forms and reports required by the commissioner as specified in the contract.

Subd. 5. **Service development and service delivery.** (a) In addition to the access, screening, and assessment activity, each local strategy may include provisions for the following:

(1) expansion of alternative care to serve an increased caseload, over the fiscal year 1991 average caseload, of at least 100 persons each year who are assessed prior to nursing home admission and persons who are relocated from nursing homes, which results in a reduction of the medical assistance nursing home caseload;

(2) the addition of a full-time staff person who is responsible to develop the following services and recruit providers as established in the contract:

(i) additional adult family foster care homes;

(ii) family adult day care providers as defined in section 256B.0919, subdivision 2;

(iii) an assisted living program in an apartment;

(iv) a congregate housing service project in a subsidized housing project; and

(v) the expansion of evening and weekend coverage of home care services as deemed necessary by the local strategic plan;

(3) small incentive grants to new adult family care providers for renovations needed to meet licensure requirements;

(4) a plan to apply for a congregate housing service project as identified in section 256.9751, authorized by the Minnesota board on aging, to the extent that funds are available;

(5) a plan to divert new applicants to nursing homes and to relocate a targeted population from nursing homes, using the individual's own resources or the funding available for services;

(6) one or more caregiver support and respite care projects, as described in subdivision 6; and

(7) one or more living-at-home/block nurse projects, as described in subdivisions 7 to 10.

(b) The expansion of alternative care clients under paragraph (a) shall be accomplished with the funds provided under section 256B.0913, and includes the allocation of targeted funds. The funding for all participating counties must be coordinated by the local long-term care coordinating team and must be part of the local long-term care strategy. Each county retains responsibility for reimbursement as defined in section 256B.0913, subdivision 12. All other requirements for the alternative care program must be met unless an exception is provided in this section. The commissioner may establish by contract a reimbursement mechanism for alternative care that does not require invoice processing through the medical assistance management information system (MMIS). The commissioner and local agencies must assure that the same client and reimbursement data is obtained as is available under MMIS.

(c) The administration of these components is the responsibility of the agencies selected by the local coordinating team and under contract with the local lead agency. However, administrative funds for paragraph (a), clauses (2) to (5), and grant funds for paragraph (a), clauses (6) and (7), shall be granted to the local lead agency. The funding available for each component is based on the plan submitted and the amount negotiated in the contract.

Subd. 6. **Statewide caregiver support and respite care resource center; caregiver support and respite care projects.** (a) The commissioner shall establish and maintain a statewide resource center for caregiver support and respite care. The resource center shall:

(1) provide information, technical assistance, and training statewide to county agencies and organizations on direct service models of caregiver support and respite care services;

(2) identify and address issues, concerns, and gaps in the statewide network for caregiver support and respite care;

(3) maintain a statewide caregiver support and respite care directory;

(4) educate caregivers on the availability and use of caregiver and respite care services;

(5) promote and expand caregiver training and support groups using existing networks when possible; and

(6) apply for and manage grants related to caregiver support and respite care.

(b) The commissioner shall establish up to 36 projects to expand the respite care network in the state and to support caregivers in their responsibilities for care. The purpose of each project shall be to:

(1) establish a local coordinated network of volunteer and paid respite workers;

(2) coordinate assignment of respite workers to clients and care receivers and assure the health and safety of the client; and

(3) provide training for caregivers and ensure that support groups are available in the community.

(c) The caregiver support and respite care funds shall be available to the four to six local long-term care strategy projects designated in subdivisions 1 to 5.

(d) The commissioner shall publish a notice in the State Register to solicit proposals from public or private nonprofit agencies for the projects not included in the four to six local long-term care strategy projects defined in subdivision 2. A county agency may, alone or in combination with other county agencies, apply for caregiver support and respite care project funds. A public or nonprofit agency may apply for project funds if the agency has a letter of agreement with the county or counties in which services will be developed, stating the intention of the county or counties to coordinate their activities with the agency requesting a grant.

(e) The commissioner shall select grantees based on the following criteria:

(1) the ability of the proposal to demonstrate need in the area served, as evidenced by a community needs assessment or other demographic data;

(2) the ability of the proposal to clearly describe how the project will achieve the purpose defined in paragraph (b);

(3) the ability of the proposal to reach underserved populations;

(4) the ability of the proposal to demonstrate community commitment to the project, as evidenced by letters of support and cooperation as well as formation of a community task force;

(5) the ability of the proposal to clearly describe the process for recruiting, training, and retraining volunteers; and

(6) the inclusion in the proposal of the plan to promote the project in the community, including outreach to persons needing the services.

(f) Funds for all projects under this subdivision may be used to:

(1) hire a coordinator to develop a coordinated network of volunteer and paid respite care services and assign workers to clients;

(2) recruit and train volunteer providers;

(3) train caregivers;

(4) ensure the development of support groups for caregivers;

(5) advertise the availability of the caregiver support and respite care project; and

(6) purchase equipment to maintain a system of assigning workers to clients.

(g) Project funds may not be used to supplant existing funding sources.

(h) An advisory committee shall be appointed to advise the caregiver support project on the development and implementation of the caregiver support and respite care services projects. The advisory committee shall review procedures and provide advice and technical assistance to the caregiver support project regarding the grant program established under this section.

The advisory committee shall consist of not more than 16 people appointed by the commissioner and shall be comprised of representatives from public and private agencies, service providers and consumers from all areas of the state.

Members of the advisory committee shall not be compensated for service.

Subd. 7. **Contract.** The commissioner of human services shall execute a contract with an organization experienced in establishing and operating community-based programs that have used the principles listed in subdivision 8, paragraph (b), in order to meet the independent living and health needs of senior citizens aged 65 and over and provide community-based long-term care for senior citizens in their homes. The organization awarded the contract shall:

(1) assist the commissioner in developing criteria for and in awarding grants to establish community-based organizations that will implement living-at-home/block nurse programs throughout the state;

(2) assist the commissioner in awarding grants to enable current living-at-home/block nurse programs 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) develop the implementation plan required by subdivision 10.

Subd. 8. **Living-at-home/block nurse program grant.** (a) The commissioner, in cooperation with the organization awarded the contract under subdivision 7, shall develop and administer a grant program to establish seven to ten community-based organizations that will implement living-at-home/block nurse programs that are designed to enable senior citizens to live as independently as possible in their homes and in their communities. Up to seven of the programs must be in counties outside the seven-county metropolitan area. The living-at-home/block nurse program funds shall be available to the four to six SAIL projects established under this section. Nonprofit

organizations and units of local government are eligible to apply for grants to establish the community organizations that will implement living-at-home/block nurse programs. In awarding grants, the commissioner shall give preference to nonprofit organizations and units of local government from communities that:

(1) have high nursing home occupancy rates;

(2) have a shortage of health care professionals; and

(3) meet other criteria established by the commissioner, in consultation with the organization under contract.

(b) Grant applicants must also meet the following criteria:

(1) the local community demonstrates a readiness to establish a community model of care, including the formation of a board of directors, advisory committee, or similar group, of which at least two-thirds is comprised of community citizens interested in community-based care for older persons;

(2) the program has sponsorship by a credible, representative organization within the community;

(3) the program has defined specific geographic boundaries and defined its organization, staffing and coordination/delivery of services;

(4) the program demonstrates a team approach to coordination and care, ensuring that the older adult participants, their families, the formal and informal providers are all part of the effort to plan and provide services; and

(5) the program provides assurances that all community resources and funding will be coordinated and that other funding sources will be maximized, including a person's own resources.

(c) Grant applicants must provide a minimum of five percent of total estimated development costs from local community funding. Grants shall be awarded for two-year periods, and the base amount shall not exceed $40,000 per applicant for the grant period. The commissioner, in consultation with the organization under contract, may increase the grant amount for applicants from communities that have socioeconomic characteristics that indicate a higher level of need for development assistance.

(d) Each living-at-home/block nurse program shall be designed by representatives of the communities being served to ensure that the program addresses the specific needs of the community residents. The programs must be designed to:

(1) incorporate the basic community, organizational, and service delivery principles of the living-at-home/block nurse program model;

(2) provide senior citizens with registered nurse directed assessment, provision and coordination of health and personal care services on a sliding fee basis as an alternative to expensive nursing home care;

(3) provide information, support services, homemaking services, counseling, and training for the client and family caregivers;

(4) encourage the development and use of respite care, caregiver support, and in-home support programs, such as adult foster care and in-home adult day care;

(5) encourage neighborhood residents and local organizations to collaborate in meeting the needs of senior citizens in their communities;

(6) recruit, train, and direct the use of volunteers to provide informal services and other appropriate support to senior citizens and their caregivers; and

(7) provide coordination and management of formal and informal services to senior citizens and their families using less expensive alternatives.

Subd. 9. **State technical assistance center.** The organization under contract shall be the state technical assistance center to provide orientation and technical assistance, and to coordinate the living-at-home/block nurse programs established. The state resource center shall:

(1) provide communities with criteria in planning and designing their living-at-home/block nurse programs;

(2) provide general orientation and technical assistance to communities who desire to establish living-at-home/block nurse programs;

(3) provide ongoing analysis and data collection of existing and newly established living-at-home/block nurse programs and provide data to the organization performing the independent assessment; and

(4) serve as the living-at-home/block nurse programs' liaison to the legislature and other state agencies.

Subd. 10. **Implementation plan.** The organization under contract shall develop a plan that specifies a strategy for implementing living-at-home/block nurse programs statewide. The plan must also analyze the data collected by the state technical assistance center and describe the effectiveness of services provided by living-at-home/block nurse programs, including the program's impact on acute care costs. The organization shall report to the commissioner of human services and to the legislature by January 1, 1993.

Subd. 11. **Evaluation and expansion.** The commissioner shall evaluate the success of the projects against the objective stated in subdivision 1, paragraph (b), and recommend to the legislature the continuation or expansion of the long-term care strategy by February 15, 1993.

Subd. 12. **Public awareness campaign.** The commissioner, with assistance from the commissioner of health and with the advice of the long-term care planning committee, shall contract for a public awareness campaign to educate the general public, seniors, consumers, caregivers, and professionals about the aging process, the long-term care system, and alternatives available including alternative care and residential alternatives. Particular emphasis will be given to informing consumers on how to access the alternatives and obtain information on the long-term care system. The commissioner shall pursue the development of new names for preadmission screening, alternative care, and foster care.

History: *1991 c 292 art 7 s 17*

256B.0919 ADULT FOSTER CARE AND FAMILY ADULT DAY CARE.

Subdivision 1. **Adult foster care licensure capacity.** Notwithstanding contrary provisions of the human services licensing act and rules adopted under it, an adult foster care license holder may care for five adults age 60 years or older who do not have serious and persistent mental illness or a developmental disability. The license holder under this section shall not be a corporate business which operates more than two facilities.

Subd. 2. **Adult foster care; family adult day care.** An adult foster care license holder who is not providing care to persons with serious and persistent mental illness or developmental disabilities may also provide family adult day care for adults age 60 years or older who do not have serious and persistent mental illness or a developmental disability. The maximum combined license capacity for adult foster care and family adult day care is five adults. A separate license is not required to provide family adult day care under this subdivision. Foster care homes providing services to five adults shall not be subject to licensure by the commissioner of health under the provisions of chapter 144, 144A, 157, or any other law requiring facility licensure by the commissioner of health.

Subd. 3. **County certification of persons providing adult foster care to related persons.** A person exempt from licensure under section 245A.03, subdivision 2, who provides adult foster care to a related individual age 65 and older, and who meets the requirements in Minnesota Rules, parts 9555.5105 to 9555.6265, may be certified by the county to provide adult foster care. A person certified by the county to provide adult foster care may be reimbursed for services provided and eligible for funding under sections 256B.0913 and 256B.0915, if the relative would suffer a financial hardship as a result of providing care. For purposes of this subdivision, financial hardship refers to a situation in which a relative incurs a substantial reduction in income as a result of resigning from a full-time job or taking a leave of absence without pay from a full-time job to care for the client.

History: *1986 c 444; 1991 c 292 art 7 s 18*

256B.092 CASE MANAGEMENT OF PERSONS WITH MENTAL RETARDATION OR RELATED CONDITIONS.

Subdivision 1. **County of financial responsibility; duties.** Before any services shall be rendered to persons with mental retardation or related conditions who are in need of social service and medical assistance, the county of financial responsibility shall conduct or arrange for a diagnostic evaluation in order to determine whether the person has or may have mental retardation or has or may have a related condition. If the county of financial responsibility determines that the person has mental retardation or a related condition, the county shall inform the person of case management services available under this section. Except as provided in subdivision 1g or 4b, if a person is diagnosed as having mental retardation or a related condition, the county of financial responsibility shall conduct or arrange for a needs assessment, develop or arrange for an individual service plan, provide or arrange for ongoing case management services at the level identified in the individual service plan, provide or arrange for case management administration, and authorize services identified in the person's individual service plan developed according to subdivision 1b. Diagnostic information, obtained by other providers or agencies, may be used to meet the diagnosis requirements of this section. Nothing in this section shall be construed as requiring: (1) assessment in areas agreed to as unnecessary by the case manager and the person, or the person's legal guardian or conservator, or the parent if the person is a minor, or (2) assessments in areas where there has been a functional assessment completed in the previous 12 months for which the case manager and the person or person's guardian or conservator, or the parent if the person is a minor, agree that further assessment is not necessary. For persons under state guardianship, the case manager shall seek authorization from the public guardianship office for waiving any assessment requirements. Assessments related to health, safety, and protection of the person for the purpose of identifying service type, amount, and frequency or assessments required to authorize services may not be waived. To the extent possible, for wards of the commissioner the county shall consider the opinions of the parent of the person with mental retardation or a related condition when developing the person's individual service plan. If the county of financial responsibility places a person in another county for services, the placement shall be made in cooperation with the county where services are provided, according to subdivision 8a, and arrangements shall be made between the two counties for ongoing social service, including annual reviews of the person's individual service plan. The county where services are provided may not make changes in the person's service plan without approval by the county of financial responsibility.

Subd. 1a. **Case management administration and services.** (a) The administrative functions of case management provided to or arranged for a person include:

(1) intake;

(2) diagnosis;

(3) screening;

(4) service authorization;

(5) review of eligibility for services; and

(6) responding to requests for conciliation conferences and appeals according to section 256.045 made by the person, the person's legal guardian or conservator, or the parent if the person is a minor.

(b) Case management service activities provided to or arranged for a person include:

(1) development of the individual service plan;

(2) informing the individual or the individual's legal guardian or conservator, or parent if the person is a minor, of service options;

(3) assisting the person in the identification of potential providers;

(4) assisting the person to access services;

(5) coordination of services;

(6) evaluation and monitoring of the services identified in the plan; and

(7) annual reviews of service plans.

(c) Case management administration and service activities that are provided to the person with mental retardation or a related condition shall be provided directly by county agencies or under contract.

Subd. 1b. **Individual service plan.** The individual service plan must:

(1) include the results of the assessment information on the person's need for service, including identification of service needs that will be or that are met by the person's relatives, friends, and others, as well as community services used by the general public;

(2) identify the person's preferences for services as stated by the person, the person's legal guardian or conservator, or the parent if the person is a minor;

(3) identify long- and short-range goals for the person;

(4) identify specific services and the amount and frequency of the services to be provided to the person based on assessed needs, preferences, and available resources. The individual service plan shall also specify other services the person needs that are not available;

(5) identify the need for an individual program plan to be developed by the provider according to the respective state and federal licensing and certification standards, and additional assessments to be completed or arranged by the provider after service initiation;

(6) identify provider responsibilities to implement and make recommendations for modification to the individual service plan;

(7) include notice of the right to request a conciliation conference or a hearing under section 256.045;

(8) be agreed upon and signed by the person, the person's legal guardian or conservator, or the parent if the person is a minor, and the authorized county representative;

(9) be reviewed by a health professional if the person has overriding medical needs that impact the delivery of services; and

(10) be completed on forms approved by the commissioner, including forms developed for interagency planning such as transition and individual family service plans.

Subd. 1c. [Repealed, 1991 c 94 s 25; c 292 art 6 s 47]

Subd. 1d. [Repealed, 1991 c 94 s 25; c 292 art 6 s 47]

Subd. 1e. [Renumbered subdivision 1f.]

Subd. 1e. **Coordination, evaluation, and monitoring of services identified in the individual service plan.** (a) If the individual service plan identifies the need for individual program plans for authorized services, the case manager shall assure that individual program plans are developed by the providers according to clauses (2) to (5). The providers shall assure that the individual program plans:

(1) are developed according to the respective state and federal licensing and certification requirements;

(2) are designed to achieve the goals of the individual service plan;

(3) are consistent with other aspects of the individual service plan;

(4) assure the health and safety of the person; and

(5) are developed with consistent and coordinated approaches to services among the various service providers.

(b) The case manager shall monitor the provision of services:

(1) to assure that the individual service plan is being followed according to paragraph (a);

(2) to identify any changes or modifications that might be needed in the individual service plan, including changes resulting from recommendations of current service providers;

(3) to determine if the person's legal rights are protected, and if not, notify the person's legal guardian or conservator, or the parent if the person is a minor, protection services, or licensing agencies as appropriate; and

(4) to determine if the person, the person's legal guardian or conservator, or the parent if the person is a minor, is satisfied with the services provided.

(c) If the provider fails to develop or carry out the individual program plan according to paragraph (a), the case manager shall notify the person's legal guardian or conservator, or the parent if the person is a minor, the provider, the respective licensing and certification agencies, and the county board where the services are being provided. In addition, the case manager shall identify other steps needed to assure the person receives the services identified in the individual service plan.

Subd. 1f. **County waiting list.** The county agency shall maintain a waiting list of persons with developmental disabilities specifying the services needed but not provided. This waiting list shall be used by county agencies to assist them in developing needed services or amending their community social services plan as required in section 256E.09, subdivision 1.

Subd. 1g. **Conditions not requiring development of individual service plan.** Unless otherwise required by federal law, the county agency is not required to complete an individual service plan as defined in subdivision 1b for:

(1) persons whose families are requesting respite care as a single service for their family member who resides with them, or whose families are requesting only a family subsidy grant and are not requesting purchase or arrangement of other habilitative or social services; and

(2) persons with mental retardation or related conditions, living independently without authorized services or receiving funding for services at a rehabilitation facility as defined in section 268A.01, subdivision 6, and not in need of or requesting additional services.

Subd. 2. **Medical assistance.** To assure quality case management to those persons who are eligible for medical assistance, the commissioner shall, upon request:

(a) provide consultation on the case management process;

(b) assist county agencies in the screening and annual reviews of clients review process to assure that appropriate levels of service are provided to persons;

(c) provide consultation on service planning and development of services with appropriate options;

(d) provide training and technical assistance to county case managers; and

(e) authorize payment for medical assistance services according to this chapter and rules implementing it.

Subd. 3. **Authorization and termination of services.** County agency case managers, under rules of the commissioner, shall authorize and terminate services of community and regional treatment center providers according to individual service plans. Services provided to persons with mental retardation or related conditions may only be authorized and terminated by case managers according to (1) rules of the commissioner and (2) the individual service plan as defined in subdivision 1b. Medical assistance services not needed shall not be authorized by county agencies or funded by the commissioner. When purchasing or arranging for unlicensed respite care services for persons with overriding health needs, the county agency shall seek the advice of a health care professional in assessing provider staff training needs and skills necessary to meet the medical needs of the person.

Subd. 4. **Home- and community-based services for persons with mental retardation or related conditions.** The commissioner shall make payments to approved vendors participating in the medical assistance program to pay costs of providing home- and community-based services, including case management service activities provided as an approved home- and community-based service, to medical assistance eligible persons with mental retardation or related conditions who have been screened under subdivi-

sion 7 and according to federal requirements. Payments for home- and community-based services shall not exceed amounts authorized by the county of financial responsibility. For specifically identified former residents of regional treatment centers and nursing facilities, the commissioner shall be responsible for authorizing payments and payment limits under the appropriate home- and community-based service program. Payment is available under this subdivision only for persons who, if not provided these services, would require the level of care provided in an intermediate care facility for persons with mental retardation or related conditions.

Subd. 4a. **Demonstration projects.** The commissioner may waive state rules governing home- and community-based services in order to demonstrate other methods of administering these services and to improve efficiency and responsiveness to individual needs of persons with mental retardation or related conditions, notwithstanding section 14.05, subdivision 4. All demonstration projects approved by the commissioner must comply with state laws and federal regulations, must remain within the fiscal limitations of the home- and community-based services program for persons with mental retardation or related conditions, and must assure the health and safety of the persons receiving services according to section 256E.08, subdivision 1.

Subd. 4b. **Case management for persons receiving home- and community-based services.** Persons authorized for and receiving home- and community-based services may select from vendors of case management which have provider agreements with the state to provide home- and community-based case management service activities. This subdivision becomes effective July 1, 1992, only if the state agency is unable to secure federal approval for limiting choice of case management vendors to the county of financial responsibility.

Subd. 5. **Federal waivers.** 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.

Subd. 6. **Rules.** The commissioner shall adopt emergency and permanent rules to establish required controls, documentation, and reporting of services provided in order to assure proper administration of the approved waiver plan, and to establish policy and procedures to reduce duplicative efforts and unnecessary paperwork on the part of case managers.

Subd. 7. **Screening teams.** For persons with mental retardation or a related condition, screening teams shall be established which shall evaluate the need for the level of care provided by residential-based habilitation services, residential services, training and habilitation services, and nursing facility services. The evaluation shall address whether home- and community-based services are appropriate for persons who are at risk of placement in an intermediate care facility for persons with mental retardation or related conditions, or for whom there is reasonable indication that they might require this level of care. The screening team shall make an evaluation of need within 15 working days of the date that the assessment is completed or within 60 working days of a request for service by a person with mental retardation or related conditions, whichever is the earlier, and within five working days of an emergency admission of a person to an intermediate care facility for persons with mental retardation or related conditions. The screening team shall consist of the case manager for persons with mental retardation or related conditions, the person, the person's legal guardian or conservator, or the parent if the person is a minor, and a qualified mental retardation

professional, as defined in the Code of Federal Regulations, title 42, section 483.430, as amended through June 3, 1988. The case manager may also act as the qualified mental retardation professional if the case manager meets the federal definition. County social service agencies may contract with a public or private agency or individual who is not a service provider for the person for the public guardianship representation required by the screening or individual service planning process. The contract shall be limited to public guardianship representation for the screening and individual service planning activities. The contract shall require compliance with the commissioner's instructions and may be for paid or voluntary services. For persons determined to have overriding health care needs, a registered nurse must be designated as either the case manager or the qualified mental retardation professional. The case manager shall consult with the person's physician, other health professionals or other individuals as necessary to make this evaluation. The case manager, with the concurrence of the person, the person's legal guardian or conservator, or the parent if the person is a minor, may invite other individuals to attend meetings of the screening team. No member of the screening team shall have any direct or indirect service provider interest in the case. Nothing in this section shall be construed as requiring the screening team meeting to be separate from the service planning meeting.

Subd. 8. **Screening team duties.** The screening team shall:

(a) review diagnostic data;

(b) review health, social, and developmental assessment data using a uniform screening tool specified by the commissioner;

(c) identify the level of services appropriate to maintain the person in the most normal and least restrictive setting that is consistent with the person's treatment needs;

(d) identify other noninstitutional public assistance or social service that may prevent or delay long-term residential placement;

(e) assess whether a person is in need of long-term residential care;

(f) make recommendations regarding placement and payment for: (1) social service or public assistance support, or both, to maintain a person in the person's own home or other place of residence; (2) training and habilitation service, vocational rehabilitation, and employment training activities; (3) community residential placement; (4) regional treatment center placement; or (5) a home- and community-based service alternative to community residential placement or regional treatment center placement;

(g) evaluate the availability, location, and quality of the services listed in paragraph (f), including the impact of placement alternatives on the person's ability to maintain or improve existing patterns of contact and involvement with parents and other family members;

(h) identify the cost implications of recommendations in paragraph (f);

(i) make recommendations to a court as may be needed to assist the court in making decisions regarding commitment of persons with mental retardation; and

(j) inform the person and the person's legal guardian or conservator, or the parent if the person is a minor, that appeal may be made to the commissioner pursuant to section 256.045.

Subd. 8a. **County concurrence.** (a) When a person has been screened and authorized for services in an intermediate care facility for persons with mental retardation or related conditions or for home- and community-based services for persons with mental retardation or related conditions, the case manager shall assist that person in identifying a service provider who is able to meet the needs of the person according to the person's individual service plan. If the identified service is to be provided in a county other than the county of financial responsibility, the county of financial responsibility shall request concurrence of the county where the person is requesting to receive the identified services. The county of service may refuse to concur if:

(1) it can demonstrate that the provider is unable to provide the services identified in the person's individual service plan as services that are needed and are to be provided;

(2) in the case of an intermediate care facility for persons with mental retardation or related conditions, there has been no authorization for admission by the admission review team as required in section 256B.0926; or

(3) in the case of home- and community-based services for persons with mental retardation or related conditions, the county of service can demonstrate that the prospective provider has failed to substantially comply with the terms of a past contract or has had a prior contract terminated within the last 12 months for failure to provide adequate services, or has received a notice of intent to terminate the contract.

(b) The county of service shall notify the county of financial responsibility of concurrence or refusal to concur no later than 20 working days following receipt of the written request. Unless other mutually acceptable arrangements are made by the involved county agencies, the county of financial responsibility is responsible for costs of social services and the costs associated with the development and maintenance of the placement. The county of service may request that the county of financial responsibility purchase case management services from the county of service or from a contracted provider of case management when the county of financial responsibility is not providing case management as defined in this section and rules adopted under this section, unless other mutually acceptable arrangements are made by the involved county agencies. Standards for payment limits under this section may be established by the commissioner. Financial disputes between counties shall be resolved as provided in section 256G.09.

Subd. 9. **Reimbursement.** Payment for services shall not be provided to a service provider for any person placed in an intermediate care facility for persons with mental retardation or related conditions prior to the person being screened by the screening team. The commissioner shall not deny reimbursement for: (a) a person admitted to an intermediate care facility for persons with mental retardation or related conditions who is assessed to need long-term supportive services, if long-term supportive services other than intermediate care are not available in that community; (b) any person admitted to an intermediate care facility for persons with mental retardation or related conditions under emergency circumstances; (c) any eligible person placed in the intermediate care facility for persons with mental retardation or related conditions pending an appeal of the screening team's decision; or (d) any medical assistance recipient when, after full discussion of all appropriate alternatives including those that are expected to be less costly than intermediate care for persons with mental retardation or related conditions, the person or the person's legal guardian or conservator, or the parent if the person is a minor, insists on intermediate care placement. The screening team shall provide documentation that the most cost effective alternatives available were offered to this individual or the individual's legal guardian or conservator.

Subd. 10. **Admission of persons to and discharge of persons from regional treatment centers.** (a) Prior to the admission of a person to a regional treatment center program for persons with mental retardation, the case manager shall make efforts to secure community-based alternatives. If these alternatives are rejected by the person, the person's legal guardian or conservator, or the county agency in favor of a regional treatment center placement, the case manager shall document the reasons why the alternatives were rejected.

(b) When discharge of a person from a regional treatment center to a community-based service is proposed, the case manager shall convene the screening team and in addition to members of the team identified in subdivision 7, the case manager shall invite to the meeting the person's parents and near relatives, and the ombudsman established under section 245.92 if the person is under public guardianship. The meeting shall be convened at a time and place that allows for participation of all team members and invited individuals who choose to attend. The notice of the meeting shall inform the person's parents and near relatives about the screening team process, and their right to request a review if they object to the discharge, and shall provide the names and functions of advocacy organizations, and information relating to assistance available to individuals interested in establishing private guardianships under the provisions of sec-

tion 252A.03. The screening team meeting shall be conducted according to subdivisions 7 and 8. Discharge of the person shall not go forward without consensus of the screening team.

(c) The results of the screening team meeting and individual service plan developed according to subdivision 1b shall be used by the interdisciplinary team assembled in accordance with Code of Federal Regulations, title 42, section 483.440, to evaluate and make recommended modifications to the individual service plan as proposed. The individual service plan shall specify postplacement monitoring to be done by the case manager according to section 253B.15, subdivision 1a.

(d) Notice of the meeting of the interdisciplinary team assembled in accordance with Code of Federal Regulations, title 42, section 483.440, shall be sent to all team members 15 days prior to the meeting, along with a copy of the proposed individual service plan. The case manager shall request that proposed providers visit the person and observe the person's program at the regional treatment center prior to the discharge. Whenever possible, preplacement visits by the person to proposed service sites should also be scheduled in advance of the meeting. Members of the interdisciplinary team assembled for the purpose of discharge planning shall include but not be limited to the case manager, the person, the person's legal guardian or conservator, parents and near relatives, the person's advocate, representatives of proposed community service providers, representatives of the regional treatment center residential and training and habilitation services, a registered nurse if the person has overriding medical needs that impact the delivery of services, and a qualified mental retardation professional specializing in behavior management if the person to be discharged has behaviors that may result in injury to self or others. The case manager may also invite other service providers who have expertise in an area related to specific service needs of the person to be discharged.

(e) The interdisciplinary team shall review the proposed plan to assure that it identifies service needs, availability of services, including support services, and the proposed providers' abilities to meet the service needs identified in the person's individual service plan. The interdisciplinary team shall review the most recent licensing reports of the proposed providers and corrective action taken by the proposed provider, if required. The interdisciplinary team shall review the current individual program plans for the person and agree to an interim individual program plan to be followed for the first 30 days in the person's new living arrangement. The interdisciplinary team may suggest revisions to the service plan, and all team suggestions shall be documented. If the person is to be discharged to a community intermediate care facility for persons with mental retardation or related conditions, the team shall give preference to facilities with a licensed capacity of 15 or fewer beds. Thirty days prior to the date of discharge, the case manager shall send a final copy of the service plan to all invited members of the team, the ombudsman, if the person is under public guardianship, and the advocacy system established under United States Code, title 42, section 6042.

(f) No discharge shall take place until disputes are resolved under section 256.045, subdivision 4a, or until a review by the commissioner is completed upon request of the chief executive officer or program director of the regional treatment center, or the county agency. For persons under public guardianship, the ombudsman may request a review or hearing under section 256.045. Notification schedules required under this subdivision may be waived by members of the team when judged urgent and with agreement of the parents or near relatives participating as members of the interdisciplinary team.

History: *1991 c 292 art 6 s 47*

256B.0925 ALTERNATIVE DELIVERY OF CASE MANAGEMENT FOR PERSONS WITH MENTAL RETARDATION OR RELATED CONDITIONS.

Subdivision 1. **Commissioner approval.** The commissioner of human services may approve proposals from up to ten county agencies to provide case management to persons with mental retardation or related conditions using alternative methods. The pro-

posals must meet criteria established by the commissioner and, to the extent possible, must represent a balance between urban, suburban, and rural counties. The commissioner's advisory task force on mental retardation, related conditions, or physical handicaps, shall review the proposals and make recommendations to the commissioner. The proposals must address one or more of the following as they relate to the provision of case management:

(1) different approaches to serving families with young children;

(2) development of consumer satisfaction surveys and other instruments to measure the quality of services;

(3) methods to decrease unnecessary paperwork;

(4) different approaches to meeting the needs of people with severe disabilities who have no connections in the community;

(5) methods to monitor the delivery of community services;

(6) alternative planning methods such as personal futures planning;

(7) utilizing parents, relatives, or self-advocates as case managers;

(8) the use of vouchers for services; and

(9) contracting for certain case management activities.

Subd. 2. **Proposal contents.** A county proposal must set forth:

(1) the activities to be undertaken;

(2) the criteria to select individuals for the program;

(3) the methods to involve individuals with mental retardation or related conditions and their families;

(4) the review and evaluation procedures that will be used;

(5) the expected outcome of the project; and

(6) the portions of Minnesota Rules, parts 9525.0015 to 9525.0165, that should be waived, the reasons for the waiver request, and the period of time for which waiver is requested.

Subd. 3. **Rule waiver.** The commissioner is authorized to grant a waiver from portions of Minnesota Rules, parts 9525.0015 to 9525.0165. The commissioner shall report to the health and human services committees of the senate and house of representatives on any portion of the rule that the commissioner is requested to waive and the disposition of the request.

Subd. 4. **Client rights.** Any client participating in the project must be informed of the portions of Minnesota Rules that are being waived. No client may be denied the client's rights or procedural protections under sections 256.045, subdivision 4a, and 256B.092.

Subd. 5. **Annual report.** The commissioner shall report to the legislature by February 1, 1993, on the results of the pilot projects and any recommendations for changes in the case management system.

History: *1986 c 444; 1991 c 25 s 1*

NOTE: The commissioner's authority under this section expires on June 30, 1993. See Laws 1991, chapter 25, section 2.

256B.0926 ADMISSION REVIEW TEAM FOR ADMISSIONS TO INTERMEDIATE CARE FACILITIES FOR PERSONS WITH MENTAL RETARDATION OR RELATED CONDITIONS.

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given them in this subdivision.

(b) "Provider" means a provider of community-based intermediate care facility services for persons with mental retardation or related conditions.

(c) "Facility" means a community-based intermediate care facility for persons with mental retardation or related conditions.

(d) "Person" means a person with mental retardation or related conditions who

is applying for admission to an intermediate care facility for persons with mental retardation or related conditions.

Subd. 2. **Admission review team; responsibilities; composition.** (a) Before a person is admitted to a facility, an admission review team must assure that the provider can meet the needs of the person as identified in the person's individual service plan required under section 256B.092, subdivision 1.

(b) The admission review team must be assembled pursuant to Code of Federal Regulations, title 42, section 483.440(b)(2). The composition of the admission review team must meet the definition of an interdisciplinary team in Code of Federal Regulations, title 42, section 483.440. In addition, the admission review team must meet any conditions agreed to by the provider and the county where services are to be provided.

(c) The county in which the facility is located may establish an admission review team which includes at least the following:

(1) a qualified mental retardation professional, as defined in Code of Federal Regulations, title 42, section 483.440;

(2) a representative of the county in which the provider is located;

(3) at least one professional representing one of the following professions: nursing, psychology, physical therapy, or occupational therapy; and

(4) a representative of the provider.

If the county in which the facility is located does not establish an admission review team, the provider shall establish a team whose composition meets the definition of an interdisciplinary team in Code of Federal Regulations, title 42, section 483.440. The provider shall invite a representative of the county agency where the facility is located to be a member of the admission review team.

Subd. 3. **Factors to be considered for admission.** (a) The determination of the team to admit a person to the facility must include, but is not limited to, consideration of the following:

(1) the preferences of the person and the person's guardian or family for services of an intermediate care facility for persons with mental retardation or related conditions;

(2) the ability of the provider to meet the needs of the person according to the person's individual service plan and the admission criteria established by the provider;

(3) the availability of a bed in the facility and of nonresidential services required by the person as specified in the person's individual service plan; and

(4) the need of the person for the services in the facility to prevent placement of the person in a more restrictive setting.

(b) When there is more than one qualified person applying for admission to the facility, the admission review team shall determine which applicant shall be offered services first, using the criteria established in this subdivision. The admission review team shall document the factors that resulted in the decision to offer services to one qualified person over another. In cases of emergency, a review of the admission by the admission review team must occur within the first 14 days of placement.

Subd. 4. **Information from provider.** The provider must establish admission criteria based on the level of service that can be provided to persons seeking admission to that facility and must provide the admission review team with the following information:

(1) a copy of the admission and level of care criteria adopted by the provider; and

(2) a written description of the services that are available to the person seeking admission, including day services, professional support services, emergency services, available direct care staffing, supervisory and administrative supports, quality assurance systems, and criteria established by the provider for discharging persons from the facility.

Subd. 5. **Establishment of admission review team; notice to provider.** When a county agency decides to establish admission review teams for the intermediate care facilities for persons with mental retardation or related conditions located in the

county, the county agency shall notify the providers of the county agency's intent at least 60 days prior to establishing the teams.

History: *1991 c 292 art 6 s 48*

256B.093 SERVICES FOR PERSONS WITH TRAUMATIC BRAIN INJURIES.

Subdivision 1. **State coordinator.** The commissioner of human services shall designate a full-time position within the long-term care management division of the department of human services to supervise and coordinate services for persons with traumatic brain injuries.

An advisory committee shall be established to provide recommendations to the department regarding program and service needs of persons with traumatic brain injuries.

Subd. 2. **Eligibility.** The commissioner may contract with qualified agencies or employ staff to provide statewide case management services to medical assistance recipients who are at risk of institutionalization and who have traumatic brain injury.

Subd. 3. **Case management duties.** The department shall fund case management under this subdivision using medical assistance administrative funds. Case management duties include:

(1) assessing the person's individual needs for services required to prevent institutionalization;

(2) ensuring that a care plan that addresses the person's needs is developed, implemented, and monitored on an ongoing basis by the appropriate agency or individual;

(3) assisting the person in obtaining services necessary to allow the person to remain in the community;

(4) coordinating home care services with other medical assistance services under section 256B.0625;

(5) ensuring appropriate, accessible, and cost-effective medical assistance services;

(6) recommending to the commissioner the approval or denial of the use of medical assistance funds to pay for home care services when home care services exceed thresholds established by the commissioner under Minnesota Rules, parts 9505.0170 to 9505.0475;

(7) assisting the person with problems related to the provision of home care services;

(8) ensuring the quality of home care services;

(9) reassessing the person's need for and level of home care services at a frequency determined by the commissioner; and

(10) recommending to the commissioner the approval or denial of medical assistance funds for out-of-state placements for traumatic brain injury services.

Subd. 4. **Definitions.** For purposes of this section, the following definitions apply:

(a) "Traumatic brain injury" means a sudden insult or damage to the brain or its coverings, not of a degenerative or congenital nature. The insult or damage may produce an altered state of consciousness and may result in a decrease in cognitive, behavioral, emotional, or physical functioning resulting in partial or total disability.

(b) "Home care services" means medical assistance home care services defined under section 256B.0625, subdivisions 6a, 7, and 19a.

History: *1991 c 292 art 7 s 19*

256B.17 TRANSFERS OF PROPERTY.

Subdivision 1. **Transfers for less than market value.** In determining the resources of an individual and an eligible spouse, there shall be included any resource or interest therein which was given away, sold, or disposed of for less than fair market value within the 24 months preceding application for medical assistance or during the period of eligibility.

Subd. 2. **Presumption of purpose.** Any transaction described in subdivision 1 shall be presumed to have been for the purpose of establishing eligibility for benefits or assistance under this chapter unless the individual or eligible spouse furnishes convincing evidence to establish that the transaction was exclusively for another purpose.

Subd. 3. **Resource value.** For purposes of subdivision 1, the value of the resource or interest shall be the fair market value at the time it was given away, sold, or disposed of, less the amount of compensation received.

Subd. 4. **Period of ineligibility.** For any uncompensated transfer, the number of months of ineligibility shall be calculated by dividing the uncompensated transferred amount by the average monthly per person payment made by the medical assistance program to skilled nursing facilities for the previous calendar year. The individual shall remain ineligible until this fixed ineligibility period has expired. The period of ineligibility may exceed 24 months, and a reapplication for benefits after 24 months from the date of the transfer shall not result in eligibility unless and until the period of ineligibility has expired.

Subd. 5. **Excluded resources.** Except for the limitations contained in subdivision 6, a resource which is transferred while otherwise excluded under sections 256B.055, 256B.056, and 256B.06 shall not be considered an available resource for purposes of medical assistance eligibility. This exception shall not apply to applicants for or recipients of general assistance medical care benefits under chapter 256D.

Subd. 6. **Prohibited transfers of excluded resources.** Any individual who is an inpatient in a skilled nursing facility or an intermediate care facility who, at any time during or after the 24-month period immediately prior to application for medical assistance, disposed of a homestead for less than fair market value shall be ineligible for medical assistance in accordance with subdivisions 1 to 4. An individual shall not be ineligible for medical assistance if one of the following conditions applies to the homestead transfer:

(1) a satisfactory showing is made that the individual can reasonably be expected to return to the homestead as a permanent residence;

(2) title to the homestead was transferred to the individual's spouse, child who is under age 21, or blind or permanently and totally disabled child as defined in the supplemental security income program;

(3) a satisfactory showing is made that the individual intended to dispose of the homestead at fair market value or for other valuable consideration; or

(4) the local agency grants a waiver of the excess resources created by the uncompensated transfer because denial of eligibility would cause undue hardship for the individual, based on imminent threat to the individual's health and well-being.

When a waiver is granted, a cause of action exists against the person to whom the homestead was transferred for that portion of medical assistance granted within 24 months of the transfer or the amount of the uncompensated transfer, whichever is less, together with the costs incurred due to the action. The action may be brought by the state or the county agency responsible for providing medical assistance under section 256B.02, subdivision 3.

Subd. 7. **Exception for asset transfers.** Notwithstanding the provisions of subdivisions 1 to 6, an institutionalized spouse who applies for medical assistance on or after July 1, 1983, may transfer liquid assets to a noninstitutionalized spouse without loss of eligibility if all of the following conditions apply:

(a) The noninstitutionalized spouse is not applying for or receiving assistance;

(b) Either (1) the noninstitutionalized spouse has less than $10,000 in liquid assets, including assets singly owned and 50 percent of assets owned jointly with the institutionalized spouse; or (2) the noninstitutionalized spouse has less than 50 percent of the total value of nonexempt assets owned by both parties, jointly or individually;

(c) The amount transferred, together with the noninstitutionalized spouse's own assets, totals no more than one-half of the total value of the liquid assets of the parties or $10,000 in liquid assets, whichever is greater; and

(d) The transfer may be effected only once, at the time of initial medical assistance application.

Subd. 8. **Conformance with federal law.** Notwithstanding the other provisions of this section, uncompensated property transfers shall be treated no more restrictively than allowed by federal law.

History: *Ex1967 c 16 s 17; 1981 c 360 art 2 s 30; 1983 c 312 art 5 s 20-24; 1984 c 534 s 23; 1985 c 252 s 23; 1986 c 444; 1987 c 403 art 2 s 83,84; 1988 c 689 art 2 s 151,268; 1989 c 282 art 3 s 98; 1990 c 568 art 3 s 95,96*

NOTE: Subdivisions 1, 2, 3, 4, 5, 6, and 8 apply to transfers that occurred before July 1, 1988. Subdivision 7 applies to persons institutionalized before October 1, 1989. See Laws 1990, chapter 568, article 3, section 95 and 96.

256B.19 DIVISION OF COST.

Subdivision 1. **Division of cost.** The state and county share of medical assistance costs not paid by federal funds shall be as follows:

(1) ninety percent state funds and ten percent county funds, unless otherwise provided below;

(2) beginning January 1, 1992, 50 percent state funds and 50 percent county funds for the cost of placement of severely emotionally disturbed children in regional treatment centers.

For counties that participate in a Medicaid demonstration project under sections 256B.69 and 256B.71, the division of the nonfederal share of medical assistance expenses for payments made to prepaid health plans or for payments made to health maintenance organizations in the form of prepaid capitation payments, this division of medical assistance expenses shall be 95 percent by the state and five percent by the county of financial responsibility.

In counties where prepaid health plans are under contract to the commissioner to provide services to medical assistance recipients, the cost of court ordered treatment ordered without consulting the prepaid health plan that does not include diagnostic evaluation, recommendation, and referral for treatment by the prepaid health plan is the responsibility of the county of financial responsibility.

Subd. 1a. **State reimbursement of counties.** Beginning July 1, 1991, the state will reimburse counties according to the payment schedule in section 256.025 for the county share of costs incurred under this subdivision on and after January 1, 1991, except for costs described in subdivision 1, clause (2). Payment to counties under this subdivision is subject to the provisions of section 256.017.

[For text of subds 2 to 2b, see M.S.1990]

Subd. 2c. **Obligation of local agency to investigate and determine eligibility for medical assistance.** (a) When the commissioner receives information that indicates that a general assistance medical care recipient or children's health plan enrollee may be eligible for medical assistance, the commissioner may notify the appropriate local agency of that fact. The local agency must investigate eligibility for medical assistance and take appropriate action and notify the commissioner of that action within 90 days from the date notice is issued. If the person is eligible for medical assistance, the local agency must find eligibility retroactively to the date on which the person met all eligibility requirements.

(b) When a prepaid health plan under a contract with the state to provide medical assistance services notifies the commissioner that an infant has been or will be born to an enrollee under the contract, the commissioner may notify the appropriate local agency of that fact. The local agency must investigate eligibility for medical assistance for the infant, take appropriate action, and notify the commissioner of that action within 90 days from the date notice is issued. If the infant would have been eligible on the date of birth, the local agency must establish eligibility retroactively to that month.

(c) For general assistance medical care recipients and children's health plan enrollees, if the local agency fails to comply with paragraph (a), the local agency is responsible

for the entire cost of general assistance medical care or children's health plan services provided from the date the commissioner issues the notice until the date the local agency takes appropriate action on the case and notifies the commissioner of the action. For infants, if the local agency fails to comply with paragraph (b), the commissioner may determine eligibility for medical assistance for the infant for a period of two months, and the local agency shall be responsible for the entire cost of medical assistance services provided for that infant, in addition to a fee of $100 for processing the case. The commissioner shall deduct any obligation incurred under this paragraph from the amount due to the local agency under subdivision 1.

[For text of subd 3, see M.S.1990]

History: *1991 c 292 art 4 s 51-53*

256B.431 RATE DETERMINATION.

[For text of subds 1 to 2k, see M.S.1990]

Subd. 2l. **Inflation adjustments after July 1, 1990.** (a) For rate years beginning on or after July 1, 1990, the forecasted composite price index for a nursing home's allowable operating cost per diems shall be determined using Data Resources, Inc., forecast for change in the Nursing Home Market Basket. The commissioner of human services shall use the indices as forecasted by Data Resources, Inc., in the fourth quarter of the calendar year preceding the rate year.

(b) For rate years beginning on or after July 1, 1992, the commissioner shall index the prior year's operating cost limits by the percentage change in the Data Resources, Inc., nursing home market basket between the midpoint of the current reporting year and the midpoint of the previous reporting year. The commissioner shall use the indices as forecasted by Data Resources, Inc., in the fourth quarter of the calendar year preceding the rate year.

Subd. 2m. **Nursing homes specializing in the treatment of Huntington's disease.** For the rate year beginning July 1, 1991, the commissioner shall reimburse nursing homes that specialize in the treatment of Huntington's disease using the case mix per diem limit that applies to nursing homes licensed under the department of human services' rules governing residential services for physically handicapped persons to establish rates for up to 35 persons with Huntington's disease. For purposes of this subdivision, a nursing home specializes in the treatment of Huntington's disease if more than 25 percent of its licensed capacity is used for residents with Huntington's disease.

Subd. 2n. **Efficiency incentive reductions for substandard care.** For rate years beginning on or after July 1, 1991, the efficiency incentive established under subdivision 2b, paragraph (d), shall be reduced or eliminated for nursing homes determined by the commissioner of health under section 144A.10, subdivision 4, to have uncorrected or repeated violations which create a risk to resident care, safety, or rights, except for uncorrected or repeated violations relating to a facility's physical plant. Upon being notified by the commissioner of health of uncorrected or repeated violations, the commissioner of human services shall require the nursing home to use efficiency incentive payments to correct the violations. The commissioner of human services shall require the nursing home to forfeit efficiency incentive payments for failure to correct the violations. Any forfeiture shall be limited to the amount necessary to correct the violation.

Subd. 2o. **Special payment rates for short-stay nursing homes.** Notwithstanding contrary provisions of this section and rules adopted by the commissioner, for the rate year beginning July 1, 1992, a nursing home whose average length of stay for the rate year beginning July 1, 1991, is less than 180 days must be reimbursed for allowable costs up to 125 percent of the total care-related limit and 105 percent of the other-operating-cost limit for hospital-attached nursing facilities. The nursing home continues to receive this rate even if the home's average length of stay is more than 180 days in the rate year subsequent to the rate year beginning July 1, 1991.

Subd. 2p. **Downsizing of nursing facilities that are institutions for mental disease.** (a) The provisions of this subdivision apply to a nursing facility that is an institution for mental disease and that has less than 23 licensed beds. A nursing facility that meets these conditions may reduce its total number of licensed beds to 16 licensed beds by July 1, 1992, by notifying the commissioner of health of the reduction by April 1, 1992. If the nursing facility elects to reduce its licensed beds to 16, the commissioner of health shall approve that request effective on the date of request.

(b) The commissioner of human services must be notified by the nursing facility of the reduction in licensed beds by April 4, 1992, and that notice must include a copy of the request for reduction submitted to the commissioner of health.

(c) For the rate year beginning July 1, 1992, the commissioner shall establish the operating cost payment rates for a nursing facility that has reduced its licensed bed capacity under this subdivision by taking into account paragraphs (1) and (2).

(1) The commissioner must reduce the nursing facility's nurse's aide, orderly, and attendant salaries account and the food expense account for the reporting year ending September 30, 1991, by 50 percent of the percentage change in licensed beds.

(2) The commissioner shall adjust the nursing facility's resident days and standardized resident days for the reporting year ending September 30, 1991, as in clauses (i) and (ii).

(i) Resident days shall be the lesser of the nursing facility's actual resident days for that reporting year or 5,840.

(ii) Standardized resident days shall be the lesser of the nursing facility's actual standardized resident days or the nursing facility's case mix score for that reporting year times 5,840.

(d) For the rate year beginning July 1, 1993, the commissioner shall establish the operating cost payment rates for a nursing facility that has reduced its licensed bed capacity under this subdivision by taking into account paragraphs (1) and (2).

(1) The commissioner must reduce the nursing facility's account for the nurse's aide, orderly, and attendant salaries, and its account for food expense for the reporting year ending September 30, 1992, by 37.5 percent of the percentage change in licensed beds.

(2) The commissioner shall adjust the nursing facility's resident days and standardized resident days for the reporting year ending September 30, 1992, as in clauses (i) and (ii).

(i) Resident days shall be the lesser of the nursing facility's actual resident days for that reporting year or 5,840.

(ii) Standardized resident days shall be the lesser of the nursing facility's actual standardized resident days or the nursing facility's case mix score for that reporting year times 5,840.

(e) If a nursing facility reduces its total number of licensed beds before June 28, 1991, by notifying the commissioner of health by that date, the dates and computations in this subdivision shall be accelerated by one year.

(f) A nursing facility eligible under this subdivision may use the notification date and the date on which the licensed beds are reduced for purposes of applying the provisions in subdivision 3a, paragraph (d), clause (2).

Subd. 2q. **Negotiated rate cap exemption.** A nursing facility which requests, after January 1991, that its boarding care beds be decertified from participation in the medical assistance program, is not eligible for the exception to the negotiated rate cap in section 256I.05, subdivision 2, paragraph (c), clause (1).

[For text of subds 3 to 3d, see M.S.1990]

Subd. 3e. **Hospital-attached convalescent and nursing care facilities.** If a nonprofit or community-operated hospital and attached convalescent and nursing care facility suspend operation of the hospital, the surviving nursing care facility must be allowed

to continue its status as a hospital-attached convalescent and nursing care facility for reimbursement purposes in five subsequent rate years. In the fourth year the facility shall receive 60 percent of the difference between the hospital-attached limit and the freestanding nursing facility limit, and in the fifth year the facility shall receive 30 percent of the difference.

Subd. 3f. **Property costs after July 1, 1988.** (a) **Investment per bed limit.** For the rate year beginning July 1, 1988, the replacement-cost-new per bed limit must be $32,571 per licensed bed in multiple bedrooms and $48,857 per licensed bed in a single bedroom. For the rate year beginning July 1, 1989, the replacement-cost-new per bed limit for a single bedroom must be $49,907 adjusted according to Minnesota Rules, part 9549.0060, subpart 4, item A, subitem (1). Beginning January 1, 1990, the replacement-cost-new per bed limits must be adjusted annually as specified in Minnesota Rules, part 9549.0060, subpart 4, item A, subitem (1). Beginning January 1, 1991, the replacement-cost-new per bed limits will be adjusted annually as specified in Minnesota Rules, part 9549.0060, subpart 4, item A, subitem (1), except that the index utilized will be the Bureau of the Census: Composite fixed-weighted price index as published in the Survey of Current Business.

(b) **Rental factor.** For the rate year beginning July 1, 1988, the commissioner shall increase the rental factor as established in Minnesota Rules, part 9549.0060, subpart 8, item A, by 6.2 percent rounded to the nearest 100th percent for the purpose of reimbursing nursing homes for soft costs and entrepreneurial profits not included in the cost valuation services used by the state's contracted appraisers. For rate years beginning on or after July 1, 1989, the rental factor is the amount determined under this paragraph for the rate year beginning July 1, 1988.

(c) **Occupancy factor.** For rate years beginning on or after July 1, 1988, in order to determine property-related payment rates under Minnesota Rules, part 9549.0060, for all nursing homes except those whose average length of stay in a skilled level of care within a nursing home is 180 days or less, the commissioner shall use 95 percent of capacity days. For a nursing home whose average length of stay in a skilled level of care within a nursing home is 180 days or less, the commissioner shall use the greater of resident days or 80 percent of capacity days but in no event shall the divisor exceed 95 percent of capacity days.

(d) **Equipment allowance.** For rate years beginning on July 1, 1988, and July 1, 1989, the commissioner shall add ten cents per resident per day to each nursing home's property-related payment rate. The ten-cent property-related payment rate increase is not cumulative from rate year to rate year. For the rate year beginning July 1, 1990, the commissioner shall increase each nursing home's equipment allowance as established in Minnesota Rules, part 9549.0060, subpart 10, by ten cents per resident per day. For rate years beginning on or after July 1, 1991, the adjusted equipment allowance must be adjusted annually for inflation as in Minnesota Rules, part 9549.0060, subpart 10, item E.

(e) **Post chapter 199 related-organization debts and interest expense.** For rate years beginning on or after July 1, 1990, Minnesota Rules, part 9549.0060, subpart 5, item E, shall not apply to outstanding related organization debt incurred prior to May 23, 1983, provided that the debt was an allowable debt under Minnesota Rules, parts 9510.0010 to 9510.0480, the debt is subject to repayment through annual principal payments, and the nursing home demonstrates to the commissioner's satisfaction that the interest rate on the debt was less than market interest rates for similar arms-length transactions at the time the debt was incurred. If the debt was incurred due to a sale between family members, the nursing home must also demonstrate that the seller no longer participates in the management or operation of the nursing home. Debts meeting the conditions of this paragraph are subject to all other provisions of Minnesota Rules, parts 9549.0010 to 9549.0080.

(f) **Building capital allowance for nursing homes with operating leases.** For rate years beginning on or after July 1, 1990, a nursing home with operating lease costs incurred for the nursing home's buildings shall receive its building capital allowance computed in accordance with Minnesota Rules, part 9549.0060, subpart 8.

[For text of subds 3g to 5, see M.S.1990]

Subd. 6. [Repealed, 1991 c 292 art 7 s 26]

[For text of subds 7 to 11, see M.S.1990]

Subd. 12. **Interim property-related payment rates.** For the rate period July 1, 1991, to June 30, 1993, the commissioner shall continue the property-related payment rate in effect on June 30, 1991, for each nursing facility, except as provided in section 256B.431, subdivision 3i, paragraphs (f) and (g), and subdivision 11, except that:

(1) A chain organization consisting of 28 nursing facilities which has a majority of owners beyond the retirement age of 62 and that has a change in ownership or reorganization of provider entity between July 1, 1991, and June 30, 1993, or until the property reimbursement system is changed, shall receive the property-related payment rate in effect at the time of the sale or reorganization. This exception is not effective until the commissioner has received approval of its state plan from the federal government; and

(2) If the property-related payment rate in effect on June 30, 1991, is later adjusted by the commissioner, the property-related payment rate for the rate period July 1, 1991, to July 1, 1993, shall also be adjusted correspondingly.

History: *1991 c 292 art 4 s 54-60; art 6 s 49,50*

256B.48 CONDITIONS FOR PARTICIPATION.

Subdivision 1. **Prohibited practices.** A nursing home is not eligible to receive medical assistance payments unless it refrains from all of the following:

(a) Charging private paying residents rates for similar services which exceed those which are approved by the state agency for medical assistance recipients as determined by the prospective desk audit rate, except under the following circumstances: the nursing home may (1) charge private paying residents a higher rate for a private room, and (2) charge for special services which are not included in the daily rate if medical assistance residents are charged separately at the same rate for the same services in addition to the daily rate paid by the commissioner. Services covered by the payment rate must be the same regardless of payment source. Special services, if offered, must be available to all residents in all areas of the nursing home and charged separately at the same rate. Residents are free to select or decline special services. Special services must not include services which must be provided by the nursing home in order to comply with licensure or certification standards and that if not provided would result in a deficiency or violation by the nursing home. Services beyond those required to comply with licensure or certification standards must not be charged separately as a special service if they were included in the payment rate for the previous reporting year. A nursing home that charges a private paying resident a rate in violation of this clause is subject to an action by the state of Minnesota or any of its subdivisions or agencies for civil damages. A private paying resident or the resident's legal representative has a cause of action for civil damages against a nursing home that charges the resident rates in violation of this clause. The damages awarded shall include three times the payments that result from the violation, together with costs and disbursements, including reasonable attorneys' fees or their equivalent. A private paying resident or the resident's legal representative, the state, subdivision or agency, or a nursing home may request a hearing to determine the allowed rate or rates at issue in the cause of action. Within 15 calendar days after receiving a request for such a hearing, the commissioner shall request assignment of an administrative law judge under sections 14.48 to 14.56 to conduct the hearing as soon as possible or according to agreement by the parties. The administrative law judge shall issue a report within 15 calendar days following the close of the hearing. The prohibition set forth in this clause shall not apply to facilities licensed as boarding care facilities which are not certified as skilled or intermediate care facilities level I or II for reimbursement through medical assistance.

(b) Requiring an applicant for admission to the home, or the guardian or conserva-

tor of the applicant, as a condition of admission, to pay any fee or deposit in excess of $100, loan any money to the nursing home, or promise to leave all or part of the applicant's estate to the home.

(c) Requiring any resident of the nursing home to utilize a vendor of health care services who is a licensed physician or pharmacist chosen by the nursing home.

(d) Providing differential treatment on the basis of status with regard to public assistance.

(e) Discriminating in admissions, services offered, or room assignment on the basis of status with regard to public assistance or refusal to purchase special services. Admissions discrimination shall include, but is not limited to:

(1) basing admissions decisions upon assurance by the applicant to the nursing home, or the applicant's guardian or conservator, that the applicant is neither eligible for nor will seek public assistance for payment of nursing home care costs; and

(2) engaging in preferential selection from waiting lists based on an applicant's ability to pay privately or an applicant's refusal to pay for a special service.

The collection and use by a nursing home of financial information of any applicant pursuant to a preadmission screening program established by law shall not raise an inference that the nursing home is utilizing that information for any purpose prohibited by this paragraph.

(f) Requiring any vendor of medical care as defined by section 256B.02, subdivision 7, who is reimbursed by medical assistance under a separate fee schedule, to pay any amount based on utilization or service levels or any portion of the vendor's fee to the nursing home except as payment for renting or leasing space or equipment or purchasing support services from the nursing home as limited by section 256B.433. All agreements must be disclosed to the commissioner upon request of the commissioner. Nursing homes and vendors of ancillary services that are found to be in violation of this provision shall each be subject to an action by the state of Minnesota or any of its subdivisions or agencies for treble civil damages on the portion of the fee in excess of that allowed by this provision and section 256B.433. Damages awarded must include three times the excess payments together with costs and disbursements including reasonable attorney's fees or their equivalent.

(g) Refusing, for more than 24 hours, to accept a resident returning to the same bed or a bed certified for the same level of care, in accordance with a physician's order authorizing transfer, after receiving inpatient hospital services.

The prohibitions set forth in clause (b) shall not apply to a retirement home with more than 325 beds including at least 150 licensed nursing home beds and which:

(1) is owned and operated by an organization tax-exempt under section 290.05, subdivision 1, clause (i); and

(2) accounts for all of the applicant's assets which are required to be assigned to the home so that only expenses for the cost of care of the applicant may be charged against the account; and

(3) agrees in writing at the time of admission to the home to permit the applicant, or the applicant's guardian, or conservator, to examine the records relating to the applicant's account upon request, and to receive an audited statement of the expenditures charged against the applicant's individual account upon request; and

(4) agrees in writing at the time of admission to the home to permit the applicant to withdraw from the home at any time and to receive, upon withdrawal, the balance of the applicant's individual account.

For a period not to exceed 180 days, the commissioner may continue to make medical assistance payments to a nursing home or boarding care home which is in violation of this section if extreme hardship to the residents would result. In these cases the commissioner shall issue an order requiring the nursing home to correct the violation. The nursing home shall have 20 days from its receipt of the order to correct the violation. If the violation is not corrected within the 20-day period the commissioner may reduce

the payment rate to the nursing home by up to 20 percent. The amount of the payment rate reduction shall be related to the severity of the violation and shall remain in effect until the violation is corrected. The nursing home or boarding care home may appeal the commissioner's action pursuant to the provisions of chapter 14 pertaining to contested cases. An appeal shall be considered timely if written notice of appeal is received by the commissioner within 20 days of notice of the commissioner's proposed action.

In the event that the commissioner determines that a nursing home is not eligible for reimbursement for a resident who is eligible for medical assistance, the commissioner may authorize the nursing home to receive reimbursement on a temporary basis until the resident can be relocated to a participating nursing home.

Certified beds in facilities which do not allow medical assistance intake on July 1, 1984, or after shall be deemed to be decertified for purposes of section 144A.071 only.

[For text of subds 1a to 8, see M.S.1990]

History: *1991 c 292 art 7 s 6*

256B.49 CHRONICALLY ILL CHILDREN; HOME AND COMMUNITY-BASED WAIVER STUDY AND APPLICATION.

[For text of subds 1 to 3, see M.S.1990]

Subd. 4. **Inflation adjustment.** For the biennium ending June 30, 1993, the commissioner of human services shall not provide an annual inflation adjustment for home and community-based waivered services, except as provided in section 256B.491, subdivision 3, and except that the commissioner shall provide an inflation adjustment for the community alternatives for disabled individuals (CADI) and community alternative care (CAC) waivered services programs for the fiscal year beginning July 1, 1991.

History: *1991 c 292 art 4 s 61*

256B.491 WAIVERED SERVICES.

[For text of subds 1 and 2, see M.S.1990]

Subd. 3. **Waivered services; salary adjustments.** For the fiscal year beginning July 1, 1991, the commissioner of human services shall increase the statewide reimbursement rates for home and community-based waivered services for persons with developmental disabilities to reflect a three percent increase in salaries, payroll taxes, and fringe benefits of personnel below top management employed by agencies under contract with the county board to provide these services. The specific rate increase made available to county boards shall be calculated based on the estimated portion of the fiscal year 1991 reimbursement rate that is attributable to these costs. County boards shall verify in writing to the commissioner that each waivered service provider has complied with this requirement. If a county board determines that a waivered service provider has not complied with this requirement for a specific contract period, the county board shall reduce the provider's payment rates for the next contract period to reflect the amount of money not spent appropriately. The commissioner shall modify reporting requirements for vendors and counties as necessary to monitor compliance with this provision.

History: *1991 c 292 art 4 s 62*

256B.50 APPEALS.

[For text of subds 1 to 1c, see M.S.1990]

Subd. 1d. **Expedited appeal review process.** (a) Within 120 days of the date an appeal is due according to subdivision 1b, the department shall review an appealed adjustment equal to or less than $100 annually per licensed bed of the provider, make a determination concerning the adjustment, and notify the provider of the determination. Except as allowed in paragraph (g), this review does not apply to an appeal of an

adjustment made to, or proposed on, an amount already paid to the provider. In this subdivision, an adjustment is each separate disallowance, allocation, or adjustment of a cost item or part of a cost item as submitted by a provider according to forms required by the commissioner.

(b) For an item on which the provider disagrees with the results of the determination of the department made under paragraph (a), the provider may, within 60 days of the date of the review notice, file with both the office of administrative hearings and the department its written argument and documents, information, or affidavits in support of its appeal. If the provider fails to make timely submissions in accordance with this paragraph, the department's determinations on the disputed items must be upheld.

(c) Within 60 days of the date the department received the provider's submission under paragraph (b), the department may file with the office of administrative hearings and serve upon the provider its written argument and documents, information, and affidavits in support of its determination. If the department fails to make a submission in accordance with this paragraph, the administrative law judge shall proceed pursuant to paragraph (d) based on the provider's submission.

(d) Upon receipt by the office of administrative hearings of the department's submission made under paragraph (c) or upon the expiration of the 60-day filing period, whichever is earlier, the chief administrative law judge shall assign the matter to an administrative law judge. The administrative law judge shall consider the submissions of the parties and all relevant rules, statutes, and case law. The administrative law judge may request additional argument from the parties if it is deemed necessary to reach a final decision, but shall not allow witnesses to be presented or discovery to be made in the proceeding. Within 60 days of receipt by the office of administrative hearings of the department's submission or the expiration of the 60-day filing period in paragraph (c), whichever is earlier, the administrative law judge shall make a final decision on the items in issue, and shall notify the provider and the department by first-class mail of the decision on each item. The decision of the administrative law judge is the final administrative decision, is not appealable, and does not create legal precedent, except that the department may make an adjustment contrary to the decision of the administrative law judge based upon a subsequent cost report amendment or field audit that reveals information relating to the adjustment that was not known to the department at the time of the final decision.

(e) For a disputed item otherwise subject to the review set forth in this subdivision, the department and the provider may mutually agree to bypass the expedited review process and proceed to a contested case hearing at any time prior to the time for the department's submission under paragraph (c).

(f) When the department determines that an appeal item subject to the review set forth in this subdivision presents the same or substantially the same adjustment presented in another appeal filed pursuant to this chapter, the department may remove the disputed items from the review in this subdivision, and the disputed items shall proceed in accordance with subdivision 1c. The department's decision to remove the appealed adjustments to contested case proceeding is final and is not reviewable.

(g) For a disputed item otherwise subject to the review in this subdivision, the department or a provider may petition the chief administrative law judge to issue an order allowing the petitioning party to bypass the expedited review process. If the petition is granted, the disputed item must proceed in accordance with subdivision 1c. In making the determination, the chief administrative law judge shall consider the potential impact and precedential and monetary value of the disputed item. A petition for removal to contested case hearing must be filed with the chief administrative law judge and the opposing party on or before the date on which its submission is due under paragraph (b) or (c). Within 20 days of receipt of the petition, the opposing party may submit its argument opposing the petition. Within 20 days of receipt of the argument opposing the petition, or if no argument is received, within 20 days of the date on which the argument was due, the chief administrative law judge shall issue a decision granting or denying the petition. If the petition is denied, the petitioning party has 60 days from the date of the denial to make a submission under paragraph (b) or (c).

(h) The department and a provider may mutually agree to use the procedures set forth in this subdivision for any disputed item not otherwise subject to this subdivision.

(i) Nothing shall prevent either party from making its submissions and arguments under this subdivision through a person who is not an attorney.

(j) This subdivision applies to all appeals for rate years beginning after June 30, 1988.

[For text of subds 1e to 2, see M.S.1990]

History: *1991 c 292 art 4 s 63*

256B.501 RATES FOR COMMUNITY-BASED SERVICES FOR PERSONS WITH MENTAL RETARDATION OR RELATED CONDITIONS.

[For text of subds 1 to 4, see M.S.1990]

Subd. 8. **Payment for persons with special needs.** The commissioner shall establish by December 31, 1983, procedures to be followed by the counties to seek authorization from the commissioner for medical assistance reimbursement for very dependent persons with special needs in an amount in excess of the rates allowed pursuant to subdivisions 2 and 4, including rates established under section 252.46 when they apply to services provided to residents of intermediate care facilities for persons with mental retardation or related conditions, and procedures to be followed for rate limitation exemptions for intermediate care facilities for persons with mental retardation or related conditions. No excess payment approved by the commissioner after June 30, 1991, shall be authorized unless:

(1) the need for specific level of service is documented in the individual service plan of the person to be served;

(2) the level of service needed can be provided within the rates established under section 252.46 and Minnesota Rules, parts 9553.0010 to 9553.0080, without a rate exception within 12 months;

(3) staff hours beyond those available under the rates established under section 252.46 and Minnesota Rules, parts 9553.0010 to 9553.0080, necessary to deliver services do not exceed 720 hours within six months;

(4) there is a basis for the estimated cost of services;

(5) the provider requesting the exception documents that current per diem rates are insufficient to support needed services;

(6) estimated costs, when added to the costs of current medical assistance-funded residential and day training and habilitation services and calculated as a per diem, do not exceed the per diem established for the regional treatment centers for persons with mental retardation and related conditions on July 1, 1990, indexed annually by the urban consumer price index, all items, published by the United States Department of Labor, for the next fiscal year over the current fiscal year;

(7) any contingencies for an approval as outlined in writing by the commissioner are met; and

(8) any commissioner orders for use of preferred providers are met.

The commissioner shall evaluate the services provided pursuant to this subdivision through program and fiscal audits.

The commissioner may terminate the rate exception at any time under any of the conditions outlined in Minnesota Rules, part 9510.1120, subpart 3, for county termination, or by reason of information obtained through program and fiscal audits which indicate the criteria outlined in this subdivision have not been, or are no longer being, met.

The commissioner may approve no more than two consecutive six-month rate exceptions for an eligible client whose first application for funding occurs after June 30, 1991.

[For text of subd 10, see M.S.1990]

Subd. 11. **Investment per bed limits, interest expense limitations, and arms-length leases.** (a) The provisions of Minnesota Rules, part 9553.0075, except as modified under this subdivision, shall apply to newly constructed or established facilities that are certified for medical assistance on or after May 1, 1990.

(b) For purposes of establishing payment rates under this subdivision and Minnesota Rules, parts 9553.0010 to 9553.0080, the term "newly constructed or newly established" means a facility (1) for which a need determination has been approved by the commissioner under sections 252.28 and 252.291; (2) whose program is newly licensed under Minnesota Rules, parts 9525.0215 to 9525.0355, and certified under Code of Federal Regulations, title 42, section 442.400, et seq.; and (3) that is part of a proposal that meets the requirements of section 252.291, subdivision 2, paragraph (2). The term does not include a facility for which a need determination was granted solely for other reasons such as the relocation of a facility; a change in the facility's name, program, number of beds, type of beds, or ownership; or the sale of a facility, unless the relocation of a facility to one or more service sites is the result of a closure of a facility under section 252.292, in which case clause (3) shall not apply. The term does include a facility that converts more than 50 percent of its licensed beds from class A to class B residential or class B institutional to serve persons discharged from state regional treatment centers on or after May 1, 1990, in which case clause (3) does not apply.

(c) Newly constructed or newly established facilities that are certified for medical assistance on or after May 1, 1990, shall be allowed the capital asset investment per bed limits as provided in clauses (1) to (4).

(1) The 1990 calendar year investment per bed limit for a facility's land must not exceed $5,700 per bed for newly constructed or newly established facilities in Hennepin, Ramsey, Anoka, Washington, Dakota, Scott, Carver, Chisago, Isanti, Wright, Benton, Sherburne, Stearns, St. Louis, Clay, and Olmsted counties, and must not exceed $3,000 per bed for newly constructed or newly established facilities in other counties.

(2) The 1990 calendar year investment per bed limit for a facility's depreciable capital assets must not exceed $44,800 for class B residential beds, and $45,200 for class B institutional beds.

(3) The investment per bed limit in clause (2) must not be used in determining the three-year average percentage increase adjustment in Minnesota Rules, part 9553.0060, subpart 1, item C, subitem (4), for facilities that were newly constructed or newly established before May 1, 1990.

(4) The investment per bed limits in clause (2) and Minnesota Rules, part 9553.0060, subpart 1, item C, subitem (2) shall be adjusted annually beginning January 1, 1991, and each January 1 following, as provided in Minnesota Rules, part 9553.0060, subpart 1, item C, subitem (2), except that the index utilized will be the Bureau of the Census: Composite fixed-weighted price index as published in the Survey of Current Business.

(d) A newly constructed or newly established facility's interest expense limitation as provided for in Minnesota Rules, part 9553.0060, subpart 3, item F, on capital debt for capital assets acquired during the interim or settle-up period, shall be increased by 2.5 percentage points for each full .25 percentage points that the facility's interest rate on its mortgage is below the maximum interest rate as established in Minnesota Rules, part 9553.0060, subpart 2, item A, subitem (2). For all following rate periods, the interest expense limitation on capital debt in Minnesota Rules, part 9553.0060, subpart 3, item F, shall apply to the facility's capital assets acquired, leased, or constructed after the interim or settle-up period. If a newly constructed or newly established facility is acquired by the state, the limitations of this paragraph and Minnesota Rules, part 9553.0060, subpart 3, item F, shall not apply.

(e) If a newly constructed or newly established facility is leased with an arms-length lease as provided for in Minnesota Rules, part 9553.0060, subpart 7, the lease agreement shall be subject to the following conditions:

(1) the term of the lease, including option periods, must not be less than 20 years;

(2) the maximum interest rate used in determining the present value of the lease must not exceed the lesser of the interest rate limitation in Minnesota Rules, part 9553.0060, subpart 2, item A, subitem (2), or 16 percent; and

(3) the residual value used in determining the net present value of the lease must be established using the provisions of Minnesota Rules, part 9553.0060.

(f) All leases of the physical plant of an intermediate care facility for the mentally retarded shall contain a clause that requires the owner to give the commissioner notice of any requests or orders to vacate the premises 90 days before such vacation of the premises is to take place. In the case of unlawful detainer actions, the owner shall notify the commissioner within three days of notice of an unlawful detainer action being served upon the tenant. The only exception to this notice requirement is in the case of emergencies where immediate vacation of the premises is necessary to assure the safety and welfare of the residents. In such an emergency situation, the owner shall give the commissioner notice of the request to vacate at the time the owner of the property is aware that the vacating of the premises is necessary. This section applies to all leases entered into after May 1, 1990. Rentals set in leases entered into after that date that do not contain this clause are not allowable costs for purposes of medical assistance reimbursement.

(g) A newly constructed or newly established facility's preopening costs are subject to the provisions of Minnesota Rules, part 9553.0035, subpart 12, and must be limited to only those costs incurred during one of the following periods, whichever is shorter:

(1) between the date the commissioner approves the facility's need determination and 30 days before the date the facility is certified for medical assistance; or

(2) the 12-month period immediately preceding the 30 days before the date the facility is certified for medical assistance.

(h) The development of any newly constructed or newly established facility as defined in this subdivision and projected to be operational after July 1, 1991, by the commissioner of human services shall be delayed until July 1, 1993, except for those facilities authorized by the commissioner as a result of a closure of a facility according to section 252.292 prior to January 1, 1991, or those facilities developed as a result of a receivership of a facility according to section 245A.12. This paragraph does not apply to state-operated community facilities authorized in section 252.50.

Subd. 12. **ICF/MR salary adjustments.** For the rate period beginning January 1, 1992, and ending September 30, 1993, the commissioner shall add the appropriate salary adjustment cost per diem calculated in paragraphs (a) to (d) to the total operating cost payment rate of each facility. The salary adjustment cost per diem must be determined as follows:

(a) **Computation and review guidelines.** Except as provided in paragraph (c), a state-operated community service, and any facility whose payment rates are governed by closure agreements, receivership agreements, or Minnesota Rules, part 9553.0075, are not eligible for a salary adjustment otherwise granted under this subdivision. For purposes of the salary adjustment per diem computation and reviews in this subdivision, the term "salary adjustment cost" means the facility's allowable program operating cost category employee training expenses, and the facility's allowable salaries, payroll taxes, and fringe benefits. The term does not include these same salary-related costs for both administrative or central office employees.

For the purpose of determining the amount of salary adjustment to be granted under this subdivision, the commissioner must use the reporting year ending December 31, 1990, as the base year for the salary adjustment per diem computation. For the purpose of each year's salary adjustment cost review, the commissioner must use the facility's salary adjustment cost for the reporting year ending December 31, 1991, as the base year. If the base year and the reporting year subject to review include salary cost reclassifications made by the department, the commissioner must reconcile those differences before completing the salary adjustment per diem review.

(b) **Salary adjustment per diem computation.** For the rate period beginning January 1, 1992, each facility shall receive a salary adjustment cost per diem equal to its salary adjustment costs multiplied by 1-1/2 percent, and then divided by the facility's resident days.

(c) **Adjustments for new facilities.** For newly constructed or newly established facilities, except for state-operated community services, whose payment rates are governed by Minnesota Rules, part 9553.0075, if the settle-up cost report includes a reporting year which is subject to review under this subdivision, the commissioner shall adjust the rule provision governing the maximum settle-up payment rate by increasing the .4166 percent for each full month of the settle-up cost report to .7083. For any subsequent rate period which is authorized for salary adjustments under this subdivision, the commissioner shall compute salary adjustment cost per diems by annualizing the salary adjustment costs for the settle-up cost report period and treat that period as the base year for purposes of reviewing salary adjustment cost per diems.

(d) **Salary adjustment per diem review.** The commissioner shall review the implementation of the salary adjustments on a per diem basis. For reporting years ending December 31, 1992, and December 31, 1993, the commissioner must review and determine the amount of change in salary adjustment costs in each of the above reporting years over the base year. In the case of each review, the commissioner must inflate the base year's salary adjustment costs by the cumulative percentage increase granted in paragraph (b), plus three percentage points for each of the two years reviewed. The commissioner must then compare each facility's salary adjustment costs for the reporting year divided by the facility's resident days for that reporting year to the base year's inflated salary adjustment cost divided by the facility's resident days for the base year. If the facility has had a one-time program operating cost adjustment settle-up during any of the reporting years subject to review, the commissioner must remove the per diem effect of the one-time program adjustment before completing the review and per diem comparison.

The review and per diem comparison must be done by the commissioner each year following the reporting years subject to review. If the salary adjustment cost per diem for the reporting year being reviewed is less than the base year's inflated salary adjustment cost per diem, the commissioner must recover the difference within 120 days after the date of written notice. The amount of the recovery shall be equal to the per diem difference multiplied by the facility's resident days in the reporting year being reviewed. Written notice of the amount subject to recovery must be given by the commissioner following each reporting year reviewed. Interest charges must be assessed by the commissioner after the 120th day of that notice at the same interest rate the commissioner assesses for other balance outstanding.

History: *1991 c 292 art 4 s 64-66*

256B.64 ATTENDANTS TO VENTILATOR-DEPENDENT RECIPIENTS.

A ventilator-dependent recipient of medical assistance who has been receiving the services of a private duty nurse or personal care assistant in the recipient's home may continue to have a private duty nurse or personal care assistant present upon admission to a hospital licensed under chapter 144. The personal care assistant or private duty nurse shall perform only the services of communicator or interpreter for the ventilator-dependent patient during a transition period of up to 120 hours to assure adequate training of the hospital staff to communicate with the patient and to understand the unique comfort, safety, and personal care needs of the patient. The personal care assistant or private duty nurse may offer nonbinding advice to the health care professionals in charge of the ventilator-dependent patient's care and treatment on matters pertaining to the comfort and safety of the patient. Within 36 hours of the end of the 120-hour transition period, an assessment may be made by the ventilator-dependent recipient, the attending physician, and the hospital staff caring for the recipient. If the persons making the assessment determine that additional communicator or interpreter services are medically necessary, the hospital must contact the commissioner 24 hours prior to

the end of the 120-hour transition period and submit the assessment information to the commissioner. The commissioner shall review the request and determine if it is medically necessary to continue the interpreter services or if the hospital staff has had sufficient opportunity to adequately determine the needs of the patient. The commissioner shall determine if continued service is necessary and appropriate and whether or not payments shall continue. The commissioner may not authorize services beyond the limits of the available appropriations for this section. The commissioner may adopt rules necessary to implement this section. Reimbursement under this section must be at the payment rate and in a manner consistent with the payment rate and manner used in reimbursing these providers for home care services for the ventilator-dependent recipient under the medical assistance program.

History: *1991 c 292 art 7 s 20*

256B.71 SOCIAL HEALTH MAINTENANCE ORGANIZATION DEMONSTRATION.

[For text of subds 1 to 4, see M.S.1990]

Subd. 5. [Repealed, 1991 c 292 art 7 s 26]

SPECIAL PAYMENTS

256B.74 SPECIAL PAYMENTS.

Subdivision 1. **Hospital reimbursement.** (a) Effective for admissions occurring on or after July 1, 1991, the commissioner shall make an indigent care payment to Minnesota and local trade area hospitals except facilities of the federal Indian Health Service and regional treatment centers, in addition to all other payment to hospitals for inpatient services. The indigent care payment shall be ten percent of the amount of medical assistance payments issued to that provider for inpatient services in a given calendar quarter or month, excluding indigent care payments paid under this section, divided by the number of related admissions, or patient days if applicable, and multiplying the result by 111 percent. The indigent care payment is added to each admission, or patient day if applicable, occurring (1) in the second calendar quarter beginning after the quarter on which the September 15, 1991, indigent care payment amount is based and (2) in the month beginning six months after the month on which the subsequent monthly indigent care payment amount is based. Medicare crossovers are excluded from indigent care payments and from the payments and admissions on which the indigent care payment is based. The commissioner may issue indigent care payments as disproportionate population adjustments for eligible hospitals.

(b) Effective for services rendered on or after July 1, 1991, the commissioner shall reimburse outpatient hospital facility fees at 80 percent of calendar year 1990 submitted charges, not to exceed the Medicare upper payment limit. Services excepted from this payment methodology are emergency room facility fees, clinic facility fees, and those services for which there is a federal maximum allowable payment.

Subd. 2. **Physician reimbursement.** The commissioner shall make payments for physician services rendered on or after July 1, 1992, as follows:

(a) Payments for level one Health Care Finance Administration's common procedural coding system (HCPCS) codes titled "office and other outpatient medical services," "preventive medicine new and established patient," "delivery, antepartum and postpartum care," caesarean delivery, and pharmacologic management provided to psychiatric patients and HCPCS level three codes for enhanced services for prenatal high risk shall be calculated at the lower of (1) submitted charges, or (2) the median charges in 1989 minus 20 percent. If the median minus 20 percent results in a decrease to rates in effect June 30, 1991, for obstetrical and prenatal services, the rate on those codes in effect on June 30, 1991, shall be increased by an additional five percent.

(b) Payments for level one HCPCS codes titled "critical care" initial or subsequent

visits only shall be calculated at the lower of (1) submitted charges, or (2) the median charges in 1989 minus 30 percent.

(c) Payments for all other services shall be calculated at the lower of (1) submitted charges, or (2) the median charges in 1989 minus 40 percent.

(d) In addition to the payment rates in paragraphs (a) to (c), rates for obstetrical services shall be adjusted by the ten percent increase in Laws 1989, chapter 689, article 1, section 2, subdivision 5, and rates for obstetrical and pediatric services shall be adjusted by the 15 percent increase in Laws 1990, chapter 568, article 1, section 2, subdivision 7.

Subd. 3. **Nursing facility reimbursement.** For rate years beginning on or after July 1, 1991, the commissioner shall reimburse nursing facilities participating in the medical assistance program as follows:

(1) a capital allowance of $1.44 per resident day shall be paid. For a licensed provider with an operating lease on the nursing facility, the capital equipment allowance shall not be the property of the lessor but shall be the property of the licensed provider for the duration of the operating lease or any renewal or extension of the operating lease; and

(2) the maximum efficiency incentive per diem payment established annually under section 256B.431, subdivision 2b, paragraph (d), shall be increased to $2.10 effective July 1, 1991, and $2.20 effective July 1, 1992.

Subd. 4. **Personal needs allowance.** The commissioner shall provide cost of living increases in the personal needs allowance under section 256B.35, subdivision 1.

Subd. 5. **Dentists.** The commissioner shall increase reimbursement to dentists for services rendered on or after July 1, 1992, by 20 percent for preventative services and five percent for all other services.

Subd. 6. **Health plans.** Effective for services rendered after July 1, 1991, the commissioner shall adjust the monthly medical assistance capitation rate cell established in contract by the amount necessary to accommodate the equivalent value of the reimbursement increase established under subdivisions 1, 2, and 5.

Subd. 7. **Administrative cost.** The commissioner may expend up to $1,700,000 for the administrative costs associated with sections 256.9657 and 256B.74.

Subd. 8. **Contingent on federal financial participation.** The provisions of this section and section 256.9657 apply only as long as federal financial participation under Title XIX of the Social Security Act is available for medical assistance payments made under this section. In the event federal financial participation is denied for payments under this section, the commissioner shall discontinue collections from providers under section 256.9657, eliminate payments to providers and recipients under this section, and implement the contingent budget reductions in Laws 1991, chapter 292, article 4, section 77, effective immediately.

Subd. 9. **No adjustments while fees in effect.** The commissioner shall not adjust the payments under this section as long as the surcharges under section 256.9657 remain in effect. The commissioner shall report to the legislature when submitting the budget forecast regarding the amount of actual and anticipated surcharge collections and provider payments. The report must include recommendations for improving the operation of this section and section 256.9657, including any changes in surcharges or payments necessary to ensure that payments under this section do not exceed collections under section 256.9657.

Subd. 10. **Implementation; rulemaking.** The commissioner shall implement sections 256.9657 and 256B.74 on July 1, 1991, without complying with the rulemaking requirements of the administrative procedure act. The commissioner shall begin to adopt emergency rules to implement Laws 1991, chapter 292, article 4, within 30 days, and may adopt permanent rules to implement Laws 1991, chapter 292, article 4. Emergency and permanent rules adopted to implement Laws 1991, chapter 292, article 4, supersede any provisions adopted under the exemption from rulemaking requirements in this section.

History: *1991 c 292 art 4 s 67*