CHAPTER 256B

MEDICAL ASSISTANCE FOR NEEDY PERSONS

256B.031 PREPAID HEALTH PLANS.

[For text of subds 1 to 3, see M.S.1998]

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 the aid to families with dependent children program formerly codified in sections 256.72 to 256.87. 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.

Subd. 5. **Free choice limited.** (a) The commissioner may require recipients of the Minnesota family investment program to enroll in a prepaid health plan and receive services from or through the prepaid health plan, with the following exceptions:

(1) recipients who are refugees and whose health services are reimbursed 100 percent by the federal government; and

(2) recipients who are placed in a foster home or facility. If placement occurs before the seventh day prior to the end of any month, the recipient will be disenrolled from the recipient's prepaid health plan effective the first day of the following month. If placement occurs after the seventh day before the end of any month, that recipient will be disenrolled from the prepaid health plan on the first day of the second month following placement. The prepaid health plan must provide all services set forth in subdivision 2 during the interim period.

Enrollment in a prepaid health plan is mandatory only when recipients have a choice of at least two prepaid health plans.

(b) Recipients who become eligible on or after December 1, 1987, must choose a health plan within 30 days of the date eligibility is determined. At the time of application, the local agency shall ask the recipient whether the recipient has a primary health care provider. If the recipient has not chosen a health plan within 30 days but has provided the local agency with the name of a primary health care provider, the local agency shall determine whether the provider participates in a prepaid health plan available to the recipient and, if so, the local agency shall select that plan on the recipient's behalf. If the recipient has not provided the name of a primary health care provider who participates in an available prepaid health plan, commissioner shall randomly assign the recipient to a health plan.

(c) If possible, the local agency shall ask whether the recipient has a primary health care provider and the procedures under paragraph (b) shall apply. If a recipient does not choose a prepaid health plan by this date, the commissioner shall randomly assign the recipient to a health plan.

(d) The commissioner shall request a waiver from the federal Health Care Financing Administration to limit a recipient's ability to change health plans to once every six or 12 months. If such a waiver is obtained, each recipient must be enrolled in the health plan for a minimum of six or 12 months. A recipient may change health plans once within the first 60 days after initial enrollment.

(e) Women who are receiving medical assistance due to pregnancy and later become eligible for the Minnesota family investment program are not required to choose a prepaid health plan until 60 days postpartum. An infant born as a result of that pregnancy must be enrolled in a prepaid health plan at the same time as the mother.

(f) If third–party coverage is available to a recipient through enrollment in a prepaid health plan through employment, through coverage by the former spouse, or if a duty of support has been imposed by law, order, decree, or judgment of a court under section 518.551, the obligee or recipient shall participate in the prepaid health plan in which the obligee has enrolled provided that the commissioner has contracted with the plan.

[For text of subds 6 to 11, see M.S.1998]

History: *1999 c 159 s 51,52*

256B.04 DUTIES OF STATE AGENCY.

[For text of subds 1 to 15, see M.S.1998]

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 modifi-

cations 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 a qualified professional supervising the personal care assistant unless the recipient selects the fiscal agent option under section 256B.0627, subdivision 10;

(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 and shall waive the requirement for personal care assistants required to join an agency for the first time during 1993 when personal care services are provided under a relative hardship waiver under section 256B.0627, subdivision 4, paragraph (b), clause (7), and at least two agencies providing personal care services have refused to employ or contract with the independent personal care assistant.

[For text of subds 17 and 18, see M.S.1998]

Subd. 19. **Performance data reporting unit.** The commissioner of human services shall establish a performance data reporting unit that serves counties and the state. The department shall support this unit and provide technical assistance and access to the data warehouse. The performance data reporting unit, which will operate within the department's central office and consist of both county and department staff, shall provide performance data reports to individual counties, share expertise from counties and the department perspective, and participate in joint planning to link with county databases and other county data sources in order to provide information on services provided to public clients from state, federal, and county funding sources. The performance data reporting unit shall provide counties both individual and group summary level standard or unique reports on health care eligibility and services provided to clients for whom they have financial responsibility.

History: *1999 c 245 art 4 s 26,27*

256B.042 THIRD PARTY LIABILITY.

Subdivision 1. **Lien for cost of care.** When the state agency provides, pays for, or becomes liable for medical care, it shall have a lien for the cost of the care upon any and all causes of action or recovery rights under any policy, plan, or contract providing benefits for health care or injury, which accrue to the person to whom the care was furnished, or to the person's legal representatives, as a result of the illness or injuries which necessitated the medical care. For purposes of this section, "state agency" includes prepaid health plans under contract with the commissioner according to sections 256B.69, 256D.03, subdivision 4, paragraph (d), and 256L.12; children's mental health collaboratives under section 245.493;

demonstration projects for persons with disabilities under section 256B.77; nursing facilities under the alternative payment demonstration project under section 256B.434; and county–based purchasing entities under section 256B.692.

Subd. 2. **Lien enforcement.** (a) The state agency may perfect and enforce its lien by following the procedures set forth in sections 514.69, 514.70 and 514.71, and its verified lien statement shall be filed with the appropriate court administrator in the county of financial responsibility. The verified lien statement shall contain the following: the name and address of the person to whom medical care was furnished, the date of injury, the name and address of the vendor or vendors furnishing medical care, the dates of the service, the amount claimed to be due for the care, and, to the best of the state agency's knowledge, the names and addresses of all persons, firms, or corporations claimed to be liable for damages arising from the injuries. This section shall not affect the priority of any attorney's lien.

(b) The state agency is not subject to any limitations period referred to in section 514.69 or 514.71 and has one year from the date notice is first received by it under subdivision 4, paragraph (c), even if the notice is untimely, or one year from the date medical bills are first paid by the state agency, whichever is later, to file its verified lien statement. The state agency may commence an action to enforce the lien within one year of (1) the date the notice required by subdivision 4, paragraph (c), is received or (2) the date the recipient's cause of action is concluded by judgment, award, settlement, or otherwise, whichever is later.

(c) If the notice required in subdivision 4 is not provided by any of the parties to the claim at any stage of the claim, the state agency will have one year from the date the state agency learns of the lack of notice to commence an action. If amounts on the claim or cause of action are paid and the amount required to be paid to the state agency under subdivision 5, is not paid to the state agency, the state agency may commence an action to recover on the lien against any or all of the parties or entities which have either paid or received the payments.

Subd. 3. The attorney general shall represent the commissioner to enforce the lien created under this section or, if no action has been brought, may initiate and prosecute an independent action on behalf of the commissioner against a person, firm, or corporation that may be liable to the person to whom the care was furnished.

Any prepaid health plan providing services under sections 256B.69, 256D.03, subdivision 4, paragraph (d), and 256L.12; children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; nursing homes under the alternative payment demonstration project under section 256B.434; or the county–based purchasing entity providing services under section 256B.692 may retain legal representation to enforce their lien created under this section or, if no action has been brought, may initiate and prosecute an independent action on their behalf against a person, firm, or corporation that may be liable to the person to whom the care or payment was furnished.

[For text of subds 4 and 5, see M.S.1998]

History: *1999 c 245 art 4 s 28–30*

256B.055 ELIGIBILITY CATEGORIES.

[For text of subds 1 to 3, see M.S.1998]

Subd. 3a. **MFIP–S families; families eligible under prior AFDC rules.** (a) Beginning January 1, 1998, or on the date that MFIP–S is implemented in counties, medical assistance may be paid for a person receiving public assistance under the MFIP–S program.

(b) Beginning January 1, 1998, medical assistance may be paid for a person who would have been eligible for public assistance under the income and resource standards, or who would have been eligible but for excess income or assets, under the state's AFDC plan in effect as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law Number 104–193.

[For text of subds 4 to 12, see M.S.1998]

History: *1999 c 245 art 4 s 31*

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

Subdivision 1. **Residency.** To be eligible for medical assistance, a person must reside in Minnesota, or, if absent from the state, be deemed to be a resident of Minnesota in accordance with the rules of the state agency.

Subd. 1a. **Income and assets generally.** Unless specifically required by state law or rule or federal law or regulation, the methodologies used in counting income and assets to determine eligibility for medical assistance for persons whose eligibility category is based on blindness, disability, or age of 65 or more years, the methodologies for the supplemental security income program shall be used. For families and children, which includes all other eligibility categories, the methodologies under the state's AFDC plan in effect as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law Number 104–193, shall be used. Effective upon federal approval, in–kind contributions to, and payments made on behalf of, a recipient, by an obligor, in satisfaction of or in addition to a temporary or permanent order for child support or maintenance, shall be considered income to the recipient. For these purposes, a "methodology" does not include an asset or income standard, or accounting method, or method of determining effective dates.

Subd. 2. **Homestead; exclusion for institutionalized persons.** The homestead shall be excluded for the first six calendar months of a person's stay in a long–term care facility and shall continue to be excluded for as long as the recipient can be reasonably expected to return to the homestead. For purposes of this subdivision, "reasonably expected to return to the homestead" means the recipient's attending physician has certified that the expectation is reasonable, and the recipient can show that the cost of care upon returning home will be met through medical assistance or other sources. The homestead shall continue to be excluded for persons residing in a long–term care facility if it is used as a primary residence by one of the following individuals:

(a) the spouse;

(b) a child under age 21;

(c) a child of any age who is blind or permanently and totally disabled as defined in the supplemental security income program;

(d) a sibling who has equity interest in the home and who resided in the home for at least one year immediately before the date of the person's admission to the facility; or

(e) a child of any age, or, subject to federal approval, a grandchild of any age, who resided in the home for at least two years immediately before the date of the person's admission to the facility, and who provided care to the person that permitted the person to reside at home rather than in an institution.

Subd. 3. **Asset limitations.** To be eligible for medical assistance, a person must not individually own more than $3,000 in assets, or if a member of a household with two family members,husband and wife, or parent and child, the household must not own more than $6,000 in assets, plus $200 for each additional legal dependent. In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. The accumulation of the clothing and personal needs allowance according to section 256B.35 must also be reduced to the maximum at the time of the eligibility redetermination. The value of assets that are not considered in determining eligibility for medical assistance is the value of those assets excluded under the AFDC state plan as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law Number 104–193, for families and children, and the supplemental security income program for aged, blind, and disabled persons, with the following exceptions:

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

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

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

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

Subd. 3a. [Repealed, 1992 c 513 art 7 s 135]

Subd. 3b. **Treatment of trusts.** (a) A "medical assistance qualifying trust" is a revocable or irrevocable trust, or similar legal device, established on or before August 10, 1993, by a person or the person's spouse under the terms of which the person receives or could receive payments from the trust principal or income and the trustee has discretion in making payments to the person from the trust principal or income. Notwithstanding that definition, a medical assistance qualifying trust does not include: (1) a trust set up by will; (2) a trust set up before April 7, 1986, solely to benefit a person with mental retardation living in an intermediate care facility for persons with mental retardation; or (3) a trust set up by a person with payments made by the Social Security Administration pursuant to the United States Supreme Court decision in Sullivan v. Zebley, 110 S. Ct. 885 (1990). The maximum amount of payments that a trustee of a medical assistance qualifying trust may make to a person under the terms of the trust is considered to be available assets to the person, without regard to whether the trustee actually makes the maximum payments to the person and without regard to the purpose for which the medical assistance qualifying trust was established.

(b) Trusts established after August 10, 1993, are treated according to section 13611(b) of the Omnibus Budget Reconciliation Act of 1993 (OBRA), Public Law Number 103–66.

Subd. 4. **Income.** To be eligible for medical assistance, a person eligible under section 256B.055, subdivision 7, not receiving supplemental security income program payments, and families and children may have an income up to 133–1/3 percent of the AFDC income standard in effect under the July 16, 1996, AFDC state plan. Effective July 1, 2000, the base AFDC standard in effect on July 16, 1996, shall be increased by three percent. Effective January 1, 2000, and each successive January, recipients of supplemental security income may have an income up to the supplemental security income standard in effect on that date. In computing income to determine eligibility of persons who are not residents of long–term care facilities, the commissioner shall disregard increases in income as required by Public Law Numbers 94–566, section 503; 99–272; and 99–509. Veterans aid and attendance benefits and Veterans Administration unusual medical expense payments are considered income to the recipient.

Subd. 4a. **Asset verification.** For purposes of verification, the value of a life estate shall be considered not salable unless the owner of the remainder interest intends to purchase the life estate, or the owner of the life estate and the owner of the remainder sell the entire property.

Subd. 4b. **Income verification.** The local agency shall not require a monthly income verification form for a recipient who is a resident of a long–term care facility and who has monthly earned income of $80 or less.

Subd. 5. **Excess income.** A person who has excess income is eligible for medical assistance if the person has expenses for medical care that are more than the amount of the person's excess income, computed by deducting incurred medical expenses from the excess income to reduce the excess to the income standard specified in subdivision 4. The person shall elect to have the medical expenses deducted at the beginning of a one–month budget period or at the beginning of a six–month budget period. The commissioner shall allow persons eligible for assistance on a one–month spenddown basis under this subdivision to elect to pay the monthly spenddown amount in advance of the month of eligibility to the state agency in order to maintain eligibility on a continuous basis. If the recipient does not pay the spenddown amount on or before the 20th of the month, the recipient is ineligible for this option for the following month. The local agency shall code the Medicaid Management Information System (MMIS) to indicate that the recipient has elected this option. The state agency shall convey recipient eligibility information relative to the collection of the spenddown to providers through the Electronic Verification System (EVS). A recipient electing advance payment must pay the state agency the monthly spenddown amount on or before the 20th of the month in order to be eligible for this option in the following month.

Subd. 5a. **Individuals on fixed income.** Recipients of medical assistance who receive only fixed unearned income, where such income is unvarying in amount and timing of receipt throughout the year, shall report and verify their income annually.

Subd. 5b. **Individuals with low income.** Recipients of medical assistance not residing in a long–term care facility who have slightly fluctuating income which is below the medical assistance income limit shall report and verify their income on a semiannual basis.

Subd. 6. **Assignment of benefits.** To be eligible for medical assistance a person must have applied or must agree to apply all proceeds received or receivable by the person or the person's spouse from any third person liable for the costs of medical care for the person, the spouse, and children. The state agency shall require from any applicant or recipient of medical assistance the assignment of any rights to medical support and third party payments. Persons must cooperate with the state in establishing paternity and obtaining third party payments. By signing an application for medical assistance, a person assigns to the department of human services all rights the person may have to medical support or payments for medical expenses from any other person or entity on their own or their dependent's behalf and agrees to cooperate with the state in establishing paternity and obtaining third party payments. Any rights or amounts so assigned shall be applied against the cost of medical care paid for under this chapter. Any assignment takes effect upon the determination that the applicant is eligible for medical assistance and up to three months prior to the date of application if the applicant is determined eligible for and receives medical assistance benefits. The application must contain a statement explaining this assignment. Any assignment shall not be effective as to benefits paid or provided under automobile accident coverage and private health care coverage prior to notification of the assignment by the person or organization providing the benefits.

Subd. 7. **Period of eligibility.** Eligibility is available for the month of application and for three months prior to application if the person was eligible in those prior months. A redetermination of eligibility must occur every 12 months.

Subd. 8. **Cooperation.** To be eligible for medical assistance, applicants and recipients must cooperate with the state and local agency to identify potentially liable third–party payers and assist the state in obtaining third party payments, unless good cause for noncooperation is determined according to Code of Federal Regulations, title 42, part 433.147. "Cooperation" includes identifying any third party who may be liable for care and services provided under this chapter to the applicant, recipient, or any other family member for whom application is made and providing relevant information to assist the state in pursuing a potentially liable third party. Cooperation also includes providing information about a group health plan for which the person may be eligible and if the plan is determined cost–effective by the state agency and premiums are paid by the local agency or there is no cost to the recipient, they must enroll or remain enrolled with the group. For purposes of this subdivision, coverage provided by the Minnesota comprehensive health association under chapter 62E shall not be considered group health plan coverage or cost–effective by the state and local agency. Cost–effective insurance premiums approved for payment by the state agency and paid by the local agency are eligible for reimbursement according to section 256B.19.

History: *1999 c 245 art 4 s 32*

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

[For text of subds 1 to 2, see M.S.1998]

Subd. 3. **Qualified Medicare beneficiaries.** A person who is entitled to Part A Medicare benefits, whose income is equal to or less than 100 percent of the federal poverty guidelines, and whose assets are no more than 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. 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.

[For text of subds 3a to 8, see M.S.1998]

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

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

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

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

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

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

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

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

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

(c) A person whose earned and unearned income is greater than 200 percent of federal poverty guidelines for the applicable family size must pay a premium to be eligible for medical assistance. The premium shall be equal to ten percent of the person's gross earned and unearned income above 200 percent of federal poverty guidelines for the applicable family size up to the cost of coverage.

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

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

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

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

History: *1999 c 245 art 4 s 33,34*

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, or a surviving spouse of a veteran having no child, the amount of an improved pension received from the veteran's administration 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 to the extent that the deduction is not included in the personal needs allowance under section 256B.35, subdivision 1, as child support garnished under a court order;

(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 reparations payments made by the Netherlands for victims of Nazi persecution between 1940 and 1945;

(8) all other exclusions from income for institutionalized persons as mandated by federal law; and

(9) 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: *1999 c 245 art 4 s 35*

256B.061 ELIGIBILITY; RETROACTIVE EFFECT; RESTRICTIONS.

(a) If any individual has been determined to be eligible for medical assistance, it will be made available for care and services included under the plan and furnished in or after the third month before the month in which the individual made application for such assistance, if such individual was, or upon application would have been, eligible for medical assistance at the time the care and services were furnished. The commissioner may limit, restrict, or suspend the eligibility of an individual for up to one year upon that individual's conviction of a criminal offense related to application for or receipt of medical assistance benefits.

(b) On the basis of information provided on the completed application, an applicant who meets the following criteria shall be determined eligible beginning in the month of application:

(1) whose gross income is less than 90 percent of the applicable income standard;

(2) whose total liquid assets are less than 90 percent of the asset limit;

(3) does not reside in a long–term care facility; and

(4) meets all other eligibility requirements.

The applicant must provide all required verifications within 30 days' notice of the eligibility determination or eligibility shall be terminated.

History: *1999 c 245 art 4 s 36*

256B.0625 COVERED SERVICES.

[For text of subds 1 to 3a, see M.S.1998]

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

(b) This subdivision expires July 1, 2001.

[For text of subds 4 to 5, see M.S.1998]

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 for residents of a hospital, nursing facility, or intermediate care facility, 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 or unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the home health services or forgoes the facility per diem for the leave days that home health services are used. 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.

[For text of subd 7, see M.S.1998]

Subd. 8. **Physical therapy.** Medical assistance covers physical therapy and related services, including specialized maintenance therapy. Services provided by a physical therapy assistant shall be reimbursed at the same rate as services performed by a physical therapist when the services of the physical therapy assistant are provided under the direction of a physical therapist who is on the premises. Services provided by a physical therapy assistant that are provided under the direction of a physical therapist who is not on the premises shall be reimbursed at 65 percent of the physical therapist rate.

Subd. 8a. **Occupational therapy.** Medical assistance covers occupational therapy and related services, including specialized maintenance therapy. Services provided by an occupational therapy assistant shall be reimbursed at the same rate as services performed by an occupational therapist when the services of the occupational therapy assistant are provided under the direction of the occupational therapist who is on the premises. Services provided by an occupational therapy assistant that are provided under the direction of an occupational therapist who is not on the premises shall be reimbursed at 65 percent of the occupational therapist rate.

Subd. 8b. **Speech language pathology services.** Medical assistance covers speech language pathology and related services, including specialized maintenance therapy.

Subd. 8c. **Care management; rehabilitation services.** (a) Effective July 1, 1999, one–time thresholds shall replace annual thresholds for provision of rehabilitation services described in subdivisions 8, 8a, and 8b. The one–time thresholds will be the same in amount and description as the thresholds prescribed by the department of human services health care programs provider manual for calendar year 1997, except they will not be renewed annually, and they will include sensory skills and cognitive training skills.

(b) A care management approach for authorization of services beyond the threshold shall be instituted in conjunction with the one–time thresholds. The care management approach shall require the provider and the department rehabilitation reviewer to work together directly through written communication, or telephone communication when appropriate, to

establish a medically necessary care management plan. Authorization for rehabilitation services shall include approval for up to 12 months of services at a time without additional documentation from the provider during the extended period, when the rehabilitation services are medically necessary due to an ongoing health condition.

(c) The commissioner shall implement an expedited five–day turnaround time to review authorization requests for recipients who need emergency rehabilitation services and who have exhausted their one–time threshold limit for those services.

[For text of subds 9 to 12, see M.S.1998]

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

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

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

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

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

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

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

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

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

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

The commissioner shall publish conditions for prohibiting payment for specific drugs after considering the formulary committee's recommendations.

(c) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs plus a fixed dispensing fee; the maximum allowable cost set by the federal government or by the commissioner plus the fixed dispensing fee; or the usual and customary price charged to the public. The pharmacy dispensing fee shall be $3.65. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. The actual acquisition cost of a drug shall be estimated by the commissioner, at average wholesale price minus nine percent. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, the maximum amount paid by other third–party payors in this state who have maximum allowable cost programs. The commissioner shall set maximum allowable costs for multisource drugs that are not on the federal upper limit list as described in United States Code, title 42, chapter 7, section 1396r–8(e), the Social Security Act, and Code of Federal Regulations, title 42, part 447, section 447.332. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act. An additional dispensing fee of $.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long–term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30–day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider will be required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse. Over–the–counter medications must be dispensed in the manufacturer's unopened package. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30–day supply. Whenever a generically equivalent product is available, payment shall be on the basis of the actual acquisition cost of the generic drug, unless the prescriber specifically indicates "dispense as written – brand necessary" on the prescription as required by section 151.21, subdivision 2.

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

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

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

(3) are sold or marketed in Minnesota.

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

[For text of subds 13a to 19b, see M.S.1998]

Subd. 19c. **Personal care.** Medical assistance covers personal care services provided by an individual who is qualified to provide the services according to subdivision 19a and section 256B.0627, where the services are prescribed by a physician in accordance with a plan of treatment and are supervised by the recipient under the fiscal agent option according to section 256B.0627, subdivision 10, or a qualified professional. "Qualified professional" means a mental health professional as defined in section 245.462, subdivision 18, or 245.4871, subdivision 26; or a registered nurse as defined in sections 148.171 to 148.285. As part of the assessment, the county public health nurse will consult with the recipient or responsible party and identify the most appropriate person to provide supervision of the per-

sonal care assistant. The qualified professional shall perform the duties described in Minnesota Rules, part 9505.0335, subpart 4.

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

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

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

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

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

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

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

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

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

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

subdivisions 17 and 23. "Increased revenue" has the meaning given in Minnesota Rules, part 9520.0903, subpart 3.

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

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

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

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

(2) programming the information systems.

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

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

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

(o) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital, and the recipient's institutional care is paid by medical assistance, payment for case management services under this subdivision is limited to the last 30 days of the recipient's residency in that facility and may not exceed more than two months in a calendar year.

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

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

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

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

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

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

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

[For text of subds 20a to 25, see M.S.1998]

Subd. 26. **Special education services.** (a) Medical assistance covers medical services identified in a recipient's individualized education plan and covered under the medical assistance state plan. Covered services include occupational therapy, physical therapy, speech–

language therapy, clinical psychological services, nursing services, school psychological services, school social work services, personal care assistants serving as management aides, assistive technology devices, transportation services, and other services covered under the medical assistance state plan. Mental health services eligible for medical assistance reimbursement must be provided or coordinated through a children's mental health collaborative where a collaborative exists if the child is included in the collaborative operational target population. The provision or coordination of services does not require that the individual education plan be developed by the collaborative.

The services may be provided by a Minnesota school district that is enrolled as a medical assistance provider or its subcontractor, and only if the services meet all the requirements otherwise applicable if the service had been provided by a provider other than a school district, in the following areas: medical necessity, physician's orders, documentation, personnel qualifications, and prior authorization requirements. The nonfederal share of costs for services provided under this subdivision is the responsibility of the local school district as provided in section 125A.74. Services listed in a child's individual education plan are eligible for medical assistance reimbursement only if those services meet criteria for federal financial participation under the Medicaid program.

(b) Approval of health–related services for inclusion in the individual education plan does not require prior authorization for purposes of reimbursement under this chapter. The commissioner may require physician review and approval of the plan not more than once annually or upon any modification of the individual education plan that reflects a change in health–related services.

(c) Services of a speech–language pathologist provided under this section are covered notwithstanding Minnesota Rules, part 9505.0390, subpart 1, item L, if the person:

(1) holds a masters degree in speech–language pathology;

(2) is licensed by the Minnesota board of teaching as an educational speech–language pathologist; and

(3) either has a certificate of clinical competence from the American Speech and Hearing Association, has completed the equivalent educational requirements and work experience necessary for the certificate or has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(d) Medical assistance coverage for medically necessary services provided under other subdivisions in this section may not be denied solely on the basis that the same or similar services are covered under this subdivision.

(e) The commissioner shall develop and implement package rates, bundled rates, or per diem rates for special education services under which separately covered services are grouped together and billed as a unit in order to reduce administrative complexity.

(f) The commissioner shall develop a cost–based payment structure for payment of these services.

(g) Effective July 1, 2000, medical assistance services provided under an individual education plan or an individual family service plan by local school districts shall not count against medical assistance authorization thresholds for that child.

[For text of subd 27, see M.S.1998]

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, a certified obstetric/gynecological nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse practitioner in independent practice, if:

(1) the service provided on an inpatient basis is not included as part of the cost for inpatient services included in the operating payment rate;

(2) the service is otherwise covered under this chapter as a physician service; and

(3) 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.1998]

Subd. 30. **Other clinic services.** (a) Medical assistance covers rural health clinic services, federally qualified health center services, nonprofit community health clinic services, public health clinic services, and the services of a clinic meeting the criteria established in rule by the commissioner. Rural health clinic services and federally qualified health center services mean services defined in United States Code, title 42, section 1396d(a)(2)(B) and (C). Payment for rural health clinic and federally qualified health center services shall be made according to applicable federal law and regulation.

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

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

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

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

[For text of subds 31 and 31a, see M.S.1998]

Subd. 32. **Nutritional products.** Medical assistance covers nutritional products needed for nutritional supplementation because solid food or nutrients thereof cannot be properly absorbed by the body or needed for treatment of phenylketonuria, hyperlysinemia, maple syrup urine disease, a combined allergy to human milk, cow's 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. Nutritional products needed for the treatment of a combined allergy to human milk, cow's milk, and soy formula require prior authorization. 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.

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

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

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

(3) in need of protection or services as defined in section 260C.007, subdivision 4.

[For text of subd 34, see M.S.1998]

Subd. 35. **Family community support services.** Medical assistance covers family community support services as defined in section 245.4871, subdivision 17. In addition to the provisions of section 245.4871, and to the extent authorized by rules promulgated by the state agency, medical assistance covers the following services as family community support services:

(1) services identified in an individual treatment plan when provided by a trained mental health behavioral aide under the direction of a mental health practitioner or mental health professional;

(2) mental health crisis intervention and crisis stabilization services provided outside of hospital inpatient settings; and

(3) the therapeutic components of preschool and therapeutic camp programs.

[For text of subds 36 to 40, see M.S.1998]

Subd. 41. **Residential services for children with severe emotional disturbance.** Medical assistance covers rehabilitative services in accordance with section 256B.0945 that are provided by a county through a residential facility, for children who have been diagnosed with severe emotional disturbance and have been determined to require the level of care provided in a residential facility.

History: *1999 c 86 art 2 s 4; 1999 c 139 art 4 s 2; 1999 c 245 art 4 s 37–49; art 5 s 20; art 8 s 5*

NOTE: The amendment to subdivision 26 by Laws 1999, chapter 245, article 4, section 45, is effective July 1, 2000. Laws 1999, chapter 245, article 4, section 121.

NOTE: Subdivision 41, as added by Laws 1999, chapter 245, article 8, section 5, is effective July 1, 2000. Laws 1999, chapter 245, article 8, section 87.

256B.0627 COVERED SERVICE; HOME CARE SERVICES.

Subdivision 1. **Definition.** (a) "Assessment" means a review and evaluation of a recipient's need for home care services conducted in person. Assessments for private duty nursing shall be conducted by a registered private duty nurse. Assessments for home health agency services shall be conducted by a home health agency nurse. Assessments for personal care assistant services shall be conducted by the county public health nurse or a certified public health nurse under contract with the county. A face–to–face assessment must include: a health status assessment and determination of need, evaluation of service outcomes, collection of case data, identification of appropriate services and service plan development or modification, coordination of services, referrals and follow–up to appropriate payers and community resources, completion of required reports, obtaining service authorization, and consumer education. A face–to–face assessment for personal care services is conducted on those recipients who have never had a county public health nurse assessment. A face–to–face assessment must occur at least annually or when there is a significant change in the recipient's condition or when there is a change in the need for personal care assistant services. A service update may substitute for the annual face–to–face assessment when there is not a significant change in recipient condition or a change in the need for personal care assistant service. A service update or review for temporary increase includes a review of initial baseline data, evaluation of service outcomes, redetermination of service need, modification of service plan and appropriate referrals, update of initial forms, obtaining service authorization, and on going consumer education. Assessments for medical assistance home care services for mental retardation or related conditions and alternative care services for developmentally disabled home and community–based waivered recipients may be conducted by the county public health nurse to ensure coordination and avoid duplication. Assessments must be completed on forms provided by the commissioner within 30 days of a request for home care services by a recipient or responsible party.

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

(c) "Home care services" means a health service, determined by the commissioner as medically necessary, that is ordered by a physician and documented in a service plan that is reviewed by the physician at least once every 62 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.

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

(e) "Personal care assistant" means a person who: (1) is at least 18 years old, except for persons 16 to 18 years of age who participated in a related school–based job training program or have completed a certified home health aide competency evaluation; (2) is able to effectively communicate with the recipient and personal care provider organization; (3) effective July 1, 1996, has completed one of the training requirements as specified in Minnesota Rules, part 9505.0335, subpart 3, items A to D; (4) has the ability to, and provides covered personal care services according to the recipient's care plan, responds appropriately to recipient needs, and reports changes in the recipient's condition to the supervising qualified professional; (5) is not a consumer of personal care services; and (6) is subject to criminal background checks and procedures specified in section 245A.04.

(f) "Personal care provider organization" means an organization enrolled to provide personal care services under the medical assistance program that complies with the following: (1) owners who have a five percent interest or more, and managerial officials are subject to a background study as provided in section 245A.04. This applies to currently enrolled personal care provider organizations and those agencies seeking enrollment as a personal care provider organization. An organization will be barred from enrollment if an owner or managerial official of the organization has been convicted of a crime specified in section 245A.04, or a comparable crime in another jurisdiction, unless the owner or managerial official meets the reconsideration criteria specified in section 245A.04; (2) the organization must maintain a surety bond and liability insurance throughout the duration of enrollment and provides proof thereof. The insurer must notify the department of human services of the cancellation or lapse of policy; and (3) the organization must maintain documentation of services as specified in Minnesota Rules, part 9505.2175, subpart 7, as well as evidence of compliance with personal care assistant training requirements.

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

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

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

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

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

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

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

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;

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

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

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

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

Subd. 4. **Personal care 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) repetitive maintenance range of motion, muscle strengthening exercises; and other tasks specific to maintaining a recipient's optimal level of function;

(4) respiratory assistance;

(5) transfers and ambulation;

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

(7) turning and positioning;

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

(9) application and maintenance of prosthetics and orthotics;

(10) cleaning medical equipment;

(11) dressing or undressing;

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

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

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

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

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

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

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

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

For purposes of this subdivision, monitoring and observation means watching for outward visible signs that are likely to occur and for which there is a covered personal care service or

an appropriate personal care intervention. For purposes of this subdivision, a clean procedure refers to a procedure that reduces the numbers of microorganisms or prevents or reduces the transmission of microorganisms from one person or place to another. A clean procedure may be used beginning 14 days after insertion.

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

(1) services not ordered by the physician;

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

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

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

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

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

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

(8) sterile procedures;

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

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

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

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

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

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

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

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

(12) home maintenance, or chore services;

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

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

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

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

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

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

(3) up to five skilled nurse visits.

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

(1) the home care services were required to treat an emergency medical condition that if not immediately treated could cause a recipient serious physical or mental disability, continuation of severe pain, or death. The provider must request retroactive authorization no later than five working days after giving the initial service. The provider must be able to substanti-

ate the emergency by documentation such as reports, notes, and admission or discharge histories;

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

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

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

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

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

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

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

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

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

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

(1) **Home health services.** All home health services provided by a licensed nurse or a home health aide must be prior authorized by the commissioner or the commissioner's designee. Prior authorization must be based on medical necessity and cost–effectiveness when compared with other care options. When home health services are used in combination with personal care and private duty nursing, the cost of all home care services shall be considered for cost–effectiveness. The commissioner shall limit nurse and home health aide visits to no more than one visit each per day.

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

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

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

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

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

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

(F) a reasonable amount of time for the provision of supervision by a qualified professional of personal care services.

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

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

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

(A) daily tube feedings;

(B) daily parenteral therapy;

(C) wound or decubiti care;

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

(E) catheterization;

(F) ostomy care;

(G) quadriplegia; or

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

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

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

(B) physical injury to other people; or

(C) destruction of property.

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

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

(A) unusual or repetitive habits;

(B) withdrawn behavior; or

(C) offensive behavior.

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

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

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

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

The commissioner may authorize:

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

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

(C) up to 16 hours per day if the recipient requires more nursing than the maximum number of direct care hours as established in item (A) and the recipient meets the hospital admission criteria established under Minnesota Rules, parts 9505.0500 to 9505.0540.

The commissioner may authorize up to 16 hours per day of medically necessary private duty nursing services or up to 24 hours per day of medically necessary private duty nursing services until such time as the commissioner is able to make a determination of eligibility for recipients who are cooperatively applying for home care services under the community alternative care program developed under section 256B.49, or until it is determined by the appropriate regulatory agency that a health benefit plan is or is not required to pay for appropriate medically necessary health care services. Recipients or their representatives must cooperatively assist the commissioner in obtaining this determination. Recipients who are eligible for the community alternative care program may not receive more hours of nursing under this section than would otherwise be authorized under section 256B.49.

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

(f) **Prior authorization; time limits.** The commissioner or the commissioner's designee shall determine the time period for which a prior authorization shall be effective. If the recipient continues to require home care services beyond the duration of the prior authorization, the home care provider must request a new prior authorization. Under no circum-

stances, other than the exceptions in paragraph (b), shall a prior authorization be valid prior to the date the commissioner receives the request or for more than 12 months. A recipient who appeals a reduction in previously authorized home care services may continue previously authorized services, other than temporary services under paragraph (h), pending an appeal under section 256.045. The commissioner must provide a detailed explanation of why the authorized services are reduced in amount from those requested by the home care provider.

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

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

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

The commissioner may not authorize:

(1) home care services that are the responsibility of the foster care provider under the terms of the foster care placement agreement and administrative rules. Requests for home care services for recipients residing in a foster care setting must include the foster care placement agreement and determination of difficulty of care;

(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 case management is provided as required in section 256B.0625, subdivision 19a;

(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 case management is provided as required in section 256B.0625, subdivision 19a;

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

(5) home care services when combined with foster care payments, other than room and board payments that exceed the total amount that public funds would pay for the recipient's care in a medical institution.

[For text of subds 6 and 7, see M.S.1998]

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

(b) Recipients of personal care assistant services may share staff and the commissioner shall provide a rate system for shared personal care assistant services. For two persons sharing services, the rate paid to a provider shall not exceed 1–1/2 times the rate paid for serving a single individual, and for three persons sharing services, the rate paid to a provider shall not exceed twice the rate paid for serving a single individual. These rates apply only to situations in which all recipients were present and received shared services on the date for which the

service is billed. No more than three persons may receive shared services from a personal care assistant in a single setting.

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

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

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

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

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

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

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

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

(e) The following items must be considered by the recipient or the responsible party and the supervising qualified professional, and documented in the recipient's health service record:

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

(2) the additional training and supervision needed by the personal care assistant to ensure that the needs of the recipient are met appropriately and safely. The provider must provide on–site supervision by a qualified professional within the first 14 days of shared services, and monthly thereafter;

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

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

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

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

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

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

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

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

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

(5) supervision of the shared personal care assistant services by the qualified professional, including the date, time of day, number of hours spent supervising the provision of

shared services, whether the supervision was face–to–face or another method of supervision, changes in the recipient's condition, shared services scheduling issues and recommendations;

(6) documentation by the qualified professional of telephone calls or other discussions with the personal care assistant regarding services being provided to the recipient; and

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

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

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

(iii) notes by the personal care assistant regarding changes in the recipient's condition, problems that may arise from the sharing of services, scheduling issues, care issues, and other notes as required by the qualified professional.

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

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

Subd. 9. **Flexible use of personal care assistant hours.** (a) The commissioner may allow for the flexible use of personal care assistant hours. "Flexible use" means the scheduled use of authorized hours of personal care assistant services, which vary within the length of the service authorization in order to more effectively meet the needs and schedule of the recipient. Recipients may use their approved hours flexibly within the service authorization period for medically necessary covered services specified in the assessment required in subdivision 1. The flexible use of authorized hours does not increase the total amount of authorized hours available to a recipient as determined under subdivision 5. The commissioner shall not authorize additional personal care assistant services to supplement a service authorization that is exhausted before the end date under a flexible service use plan, unless the county public health nurse determines a change in condition and a need for increased services is established.

(b) The recipient or responsible party, together with the county public health nurse, shall determine whether flexible use is an appropriate option based on the needs and preferences of the recipient or responsible party, and, if appropriate, must ensure that the allocation of hours covers the ongoing needs of the recipient over the entire service authorization period. As part of the assessment and service planning process, the recipient or responsible party must work with the county public health nurse to develop a written month–to–month plan of the projected use of personal care assistant services that is part of the service plan and ensures that the:

(1) health and safety needs of the recipient will be met;

(2) total annual authorization will not exceed before the end date; and

(3) how actual use of hours will be monitored.

(c) If the actual use of personal care assistant service varies significantly from the use projected in the plan, the written plan must be promptly updated by the recipient or responsible party and the county public health nurse.

(d) The recipient or responsible party, together with the provider, must work to monitor and document the use of authorized hours and ensure that a recipient is able to manage services effectively throughout the authorized period. The provider must ensure that the month–to–month plan is incorporated into the care plan. Upon request of the recipient or responsible party, the provider must furnish regular updates to the recipient or responsible party on the amount of personal care assistant services used.

(e) The recipient or responsible party may revoke the authorization for flexible use of hours by notifying the provider and county public health nurse in writing.

(f) If the requirements in paragraphs (a) to (e) have not substantially been met, the commissioner shall deny, revoke, or suspend the authorization to use authorized hours flexibly. The recipient or responsible party may appeal the commissioner's action according to section 256.045. The denial, revocation, or suspension to use the flexible hours option shall not

affect the recipient's authorized level of personal care assistant services as determined under subdivision 5.

Subd. 10. **Fiscal agent option available for personal care assistant services.** (a) "Fiscal agent option" is an option that allows the recipient to:

(1) use a fiscal agent instead of a personal care provider organization;

(2) supervise the personal care assistant; and

(3) use a consulting professional.

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

(b) The recipient or responsible party shall:

(1) hire, and terminate the personal care assistant and consulting professional, with the fiscal agent;

(2) recruit the personal care assistant and consulting professional and orient and train the personal care assistant in areas that do not require professional delegation as determined by the county public health nurse;

(3) supervise and evaluate the personal care assistant in areas that do not require professional delegation as determined in the assessment;

(4) cooperate with a consulting professional and implement recommendations pertaining to the health and safety of the recipient;

(5) hire a qualified professional to train and supervise the performance of delegated tasks done by the personal care assistant;

(6) monitor services and verify in writing the hours worked by the personal care assistant and the consulting professional;

(7) develop and revise a care plan with assistance from a consulting professional;

(8) verify and document the credentials of the consulting professional; and

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

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

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

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

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

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

(5) verify and document hours worked by the personal care assistant and consulting professional;

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

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

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

(d) The fiscal agent:

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

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

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

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

(e) The consulting professional providing assistance to the recipient shall meet the qualifications specified in section 256B.0625, subdivision 19c. The consulting professional shall assist the recipient in developing and revising a plan to meet the recipient's assessed needs, and supervise the performance of delegated tasks, as determined by the public health nurse. In performing this function, the consulting professional must visit the recipient in the recipient's home at least once annually. The consulting professional must report to the local county public health nurse concerns relating to the health and safety of the recipient, and any suspected abuse, neglect, or financial exploitation of the recipient to the appropriate authorities.

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

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

(2) the salary and benefits for the personal care assistant and those providing professional consultation;

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

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

(5) procedures for hiring and terminating the personal care assistant and those providing professional consultation.

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

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

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

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

(3) a face–to–face assessment must be conducted by the local county public health nurse at least annually, or when there is a significant change in the recipient's condition or change in the need for personal care assistant services. The county public health nurse shall determine the services that require professional delegation, if any, and the amount and frequency of related supervision;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) The recipient or the recipient's legal representative, in conjunction with the private duty nursing agency, shall approve the setting, grouping, and arrangement of shared private duty nursing care based on the individual needs and preferences of the recipients. Decisions on the selection of recipients to share services must be based on the ages of the recipients, compatibility, and coordination of their care needs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 12. **Public health nurse assessment rate.** (a) The reimbursement rates for public health nurse visits that relate to the provision of personal care services under this section and section 256B.0625, subdivision 19a, are:

(i) $210.50 for a face–to–face assessment visit;

(ii) $105.25 for each service update; and

(iii) $105.25 for each request for a temporary service increase.

(b) The rates specified in paragraph (a) must be adjusted to reflect provider rate increases for personal care assistant services that are approved by the legislature for the fiscal year ending June 30, 2000, and subsequent fiscal years. Any requirements applied by the legislature to provider rate increases for personal care assistant services also apply to adjustments under this paragraph.

History: *1999 c 245 art 4 s 50–58*

NOTE: Subdivision 10, as added by Laws 1999, chapter 245, article 4, section 56, is effective upon federal approval. Laws 1999, chapter 245, article 4, section 121.

256B.0635 CONTINUED ELIGIBILITY IN SPECIAL CIRCUMSTANCES.

[For text of subds 1 and 2, see M.S.1998]

Subd. 3. **Medical assistance for MFIP–S participants who opt to discontinue monthly cash assistance.** Medical assistance is available to persons who opt to discontinue receiving MFIP–S cash assistance under section 256J.31, subdivision 12. A person who is eligible for medical assistance under this section may receive medical assistance without reapplication as long as the person meets MFIP–S eligibility requirements. Medical assistance may be paid pursuant to subdivisions 1 and 2 for persons who are no longer eligible for MFIP–S due to increased employment or child support. A person may be eligible for MinnesotaCare due to increased employment or child support, and as such must be informed of the option to transition onto MinnesotaCare.

History: *1999 c 245 art 4 s 59*

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

A vendor of medical care, as defined in section 256B.02, subdivision 7, and a health maintenance organization, as defined in chapter 62D, must participate as a provider or contractor in the medical assistance program, general assistance medical care program, and MinnesotaCare as a condition of participating as a provider in health insurance plans and programs or contractor for state employees established under section 43A.18, the public em-

ployees insurance program under section 43A.316, for health insurance plans offered to local statutory or home rule charter city, county, and school district employees, the workers' compensation system under section 176.135, and insurance plans provided through the Minnesota comprehensive health association under sections 62E.01 to 62E.19. The limitations on insurance plans offered to local government employees shall not be applicable in geographic areas where provider participation is limited by managed care contracts with the department of human services. For providers other than health maintenance organizations, participation in the medical assistance program means that (1) the provider accepts new medical assistance, general assistance medical care, and MinnesotaCare patients or (2) at least 20 percent of the provider's patients are covered by medical assistance, general assistance medical care, and MinnesotaCare as their primary source of coverage. The commissioner shall establish participation requirements for health maintenance organizations. The commissioner shall provide lists of participating medical assistance providers on a quarterly basis to the commissioner of employee relations, the commissioner of labor and industry, and the commissioner of commerce. Each of the commissioners shall develop and implement procedures to exclude as participating providers in the program or programs under their jurisdiction those providers who do not participate in the medical assistance program. The commissioner of employee relations shall implement this section through contracts with participating health and dental carriers.

History: *1999 c 177 s 87*

256B.0911 NURSING FACILITY PREADMISSION SCREENING.

[For text of subds 1 to 5, see M.S.1998]

Subd. 6. **Payment for preadmission screening.** (a) The total screening payment for each county must be paid monthly by certified nursing facilities in the county. The monthly amount to be paid by each nursing facility for each fiscal year must be determined by dividing the county's annual allocation for screenings by 12 to determine the monthly payment and allocating the monthly payment to each nursing facility based on the number of licensed beds in the nursing facility.

(b) The commissioner shall include the total annual payment for screening for each nursing facility according to section 256B.431, subdivision 2b, paragraph (g), or 256B.435.

(c) Payments for screening activities are available to the county or counties to cover staff salaries and expenses to provide the screening function. The lead agency shall employ, or contract with other agencies to employ, within the limits of available funding, sufficient personnel to conduct the preadmission screening activity while meeting the state's long-term care outcomes and objectives as defined in section 256B.0917, subdivision 1. The local agency shall be accountable for meeting local objectives as approved by the commissioner in the CSSA biennial plan.

(d) Notwithstanding section 256B.0641, overpayments attributable to payment of the screening costs under the medical assistance program may not be recovered from a facility.

(e) The commissioner of human services shall amend the Minnesota medical assistance plan to include reimbursement for the local screening teams.

[For text of subds 7 to 9, see M.S.1998]

History: *1999 c 245 art 3 s 12*

256B.0913 ALTERNATIVE CARE PROGRAM.

[For text of subds 1 to 4, see M.S.1998]

Subd. 5. **Services covered under alternative care.** (a) Alternative care funding may be used for payment of costs of:

(1) adult foster care;

(2) adult day care;

(3) home health aide;

(4) homemaker services;
(5) personal care;
(6) case management;
(7) respite care;
(8) assisted living;
(9) residential care services;
(10) care–related supplies and equipment;
(11) meals delivered to the home;
(12) transportation;
(13) skilled nursing;
(14) chore services;
(15) companion services;
(16) nutrition services;
(17) training for direct informal caregivers;
(18) telemedicine devices to monitor recipients in their own homes as an alternative to hospital care, nursing home care, or home visits; and
(19) other services including direct cash payments to clients, approved by the county agency, subject to the provisions of paragraph (m). Total annual payments for other services for all clients within a county may not exceed either ten percent of that county's annual alternative care program base allocation or $5,000, whichever is greater. In no case shall this amount exceed the county's total annual alternative care program base allocation.

(b) 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.

(c) Unless specified in statute, the service standards for alternative care services shall be the same as the service standards defined in the elderly waiver. Except for the county agencies' approval of direct cash payments to clients, persons or agencies must be employed by or under a contract with the county agency or the public health nursing agency of the local board of health in order to receive funding under the alternative care program.

(d) The adult foster care rate shall be considered a difficulty of care payment and shall not include room and board. The adult foster care daily rate shall be negotiated between the county agency and the foster care provider. The rate established under this section shall not exceed 75 percent of the state average monthly nursing home payment for the case mix classification to which the individual receiving foster care is assigned, and it must allow for other alternative care services to be authorized by the case manager.

(e) 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.

(f) A county may use alternative care funds to purchase medical supplies and equipment without prior approval from the commissioner when: (1) there is no other funding source; (2) the supplies and equipment are specified in the individual's care plan as medically necessary to enable the individual to remain in the community according to the criteria in Minnesota Rules, part 9505.0210, item A; and (3) the supplies and equipment represent an effective and appropriate use of alternative care funds. A county may use alternative care funds to purchase supplies and equipment from a non–Medicaid certified vendor if the cost for the items is less than that of a Medicaid vendor. A county is not required to contract with a provider of supplies and equipment if the monthly cost of the supplies and equipment is less than $250.

(g) For purposes of this section, residential care services are services which are provided to individuals living in residential care homes. Residential care homes are currently licensed as board and lodging establishments and are registered with the department of health as providing special services. Residential care services are defined as "supportive services" and "health–related services." "Supportive services" means the provision of up to 24–hour supervision and oversight. Supportive services includes: (1) transportation, when

provided by the residential care center only; (2) socialization, when socialization is part of the plan of care, has specific goals and outcomes established, and is not diversional or recreational in nature; (3) assisting clients in setting up meetings and appointments; (4) assisting clients in setting up medical and social services; (5) providing assistance with personal laundry, such as carrying the client's laundry to the laundry room. Assistance with personal laundry does not include any laundry, such as bed linen, that is included in the room and board rate. Health–related services are limited to minimal assistance with dressing, grooming, and bathing and providing reminders to residents to take medications that are self–administered or providing storage for medications, if requested. Individuals receiving residential care services cannot receive both personal care services and residential care services.

(h) For the purposes of this section, "assisted living" refers to supportive services provided by a single vendor to clients who reside in the same apartment building of three or more units which are not subject to registration under chapter 144D. Assisted living services are defined as up to 24–hour supervision, and oversight, supportive services as defined in clause (1), individualized home care aide tasks as defined in clause (2), and individualized home management tasks as defined in clause (3) provided to residents of a residential center living in their units or apartments with a full kitchen and bathroom. A full kitchen includes a stove, oven, refrigerator, food preparation counter space, and a kitchen utensil storage compartment. Assisted living services must be provided by the management of the residential center or by providers under contract with the management or with the county.

(1) Supportive services include:

(i) socialization, when socialization is part of the plan of care, has specific goals and outcomes established, and is not diversional or recreational in nature;

(ii) assisting clients in setting up meetings and appointments; and

(iii) providing transportation, when provided by the residential center only.

Individuals receiving assisted living services will not receive both assisted living services and homemaking or personal care services. Individualized means services are chosen and designed specifically for each resident's needs, rather than provided or offered to all residents regardless of their illnesses, disabilities, or physical conditions.

(2) Home care aide tasks means:

(i) preparing modified diets, such as diabetic or low sodium diets;

(ii) reminding residents to take regularly scheduled medications or to perform exercises;

(iii) household chores in the presence of technically sophisticated medical equipment or episodes of acute illness or infectious disease;

(iv) household chores when the resident's care requires the prevention of exposure to infectious disease or containment of infectious disease; and

(v) assisting with dressing, oral hygiene, hair care, grooming, and bathing, if the resident is ambulatory, and if the resident has no serious acute illness or infectious disease. Oral hygiene means care of teeth, gums, and oral prosthetic devices.

(3) Home management tasks means:

(i) housekeeping;

(ii) laundry;

(iii) preparation of regular snacks and meals; and

(iv) shopping.

Assisted living services as defined in this section shall not be authorized in boarding and lodging establishments licensed according to sections 157.011 and 157.15 to 157.22.

(i) For establishments registered under chapter 144D, assisted living services under this section means the services described and licensed under section 144A.4605.

(j) For the purposes of this section, reimbursement for assisted living services and residential care services shall be a monthly rate negotiated and authorized by the county agency based on an individualized service plan for each resident. The rate shall not exceed the nonfederal share of the greater of either the statewide or any of the geographic groups' weighted 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, unless the services are provided by a home care provider licensed by the department of health and are provided in a building that is registered as a housing with services establishment under chapter 144D and that provides 24–hour supervision.

(k) 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 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.

(l) 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.

(m) A county agency may make payment from their alternative care program allocation for other services provided to an alternative care program recipient if those services prevent, shorten, or delay institutionalization. These services may include direct cash payments to the recipient for the purpose of purchasing the recipient's services. The following provisions apply to payments under this paragraph:

(1) a cash payment to a client under this provision cannot exceed 80 percent of the monthly payment limit for that client as specified in subdivision 4, paragraph (a), clause (7);

(2) a county may not approve any cash payment for a client who has been assessed as having a dependency in orientation, unless the client has an authorized representative under section 256.476, subdivision 2, paragraph (g), or for a client who is concurrently receiving adult foster care, residential care, or assisted living services;

(3) any service approved under this section must be a service which meets the purpose and goals of the program as listed in subdivision 1;

(4) cash payments must also meet the criteria in section 256.476, subdivision 4, paragraph (b), and recipients of cash grants must meet the requirements in section 256.476, subdivision 10; and

(5) the county shall report client outcomes, services, and costs under this paragraph in a manner prescribed by the commissioner.

Upon implementation of direct cash payments to clients under this section, any person determined eligible for the alternative care program who chooses a cash payment approved by the county agency shall receive the cash payment under this section and not under section 256.476 unless the person was receiving a consumer support grant under section 256.476 before implementation of direct cash payments under this section.

[For text of subds 6 to 9, see M.S.1998]

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. Calculations for paragraphs (c) and (d) must also include the funds transferred to the consumer support grant program for clients who have transferred to that program from April 1 through March 31 in the base year.

(g) For the biennium ending June 30, 2001, the allocation of state funds to county agencies shall be calculated as described in paragraphs (c) and (d). If the annual legislative appropriation for the alternative care program is inadequate to fund the combined county allocations for fiscal year 2000 or 2001, the commissioner shall distribute to each county the entire annual appropriation as that county's percentage of the computed base as calculated in paragraph (f).

[For text of subd 11, see M.S.1998]

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. The amount of the premium for the alternative care client shall be determined as follows:

(1) when the alternative care client's income less recurring and predictable medical expenses is greater than the medical assistance income standard but less than 150 percent of the federal poverty guideline, and total assets are less than $10,000, the fee is zero;

(2) when the alternative care client's income less recurring and predictable medical expenses is greater than 150 percent of the federal poverty guideline, and total assets are less than $10,000, the fee is 25 percent of the cost of alternative care services or the difference between 150 percent of the federal poverty guideline and the client's income less recurring and predictable medical expenses, whichever is less; and

(3) when the alternative care client's total assets are greater than $10,000, the fee is 25 percent of the cost of alternative care services.

For married persons, total assets are defined as the total marital assets less the estimated community spouse asset allowance, under section 256B.059, if applicable. For married persons, total income is defined as the client's income less the monthly spousal allotment, under section 256B.058.

All alternative care services except case management shall be included in the estimated costs for the purpose of determining 25 percent of the costs.

The monthly premium shall be calculated based on the cost of the first full month of alternative care services and shall continue unaltered until the next reassessment is completed or at the end of 12 months, whichever comes first. Premiums are due and payable each month alternative care services are received unless the actual cost of the services is less than the premium.

(b) The fee shall be waived by the commissioner when:

(1) a person who is residing in a nursing facility is receiving case management only;

(2) a person is applying for medical assistance;

(3) a married couple is requesting an asset assessment under the spousal impoverishment provisions;

(4) a person is a medical assistance recipient, but has been approved for alternative care–funded assisted living services;

(5) a person is found eligible for alternative care, but is not yet receiving alternative care services; or

(6) a person's fee under paragraph (a) is less than $25.

(c) 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.

(d) The commissioner shall begin to adopt emergency or permanent rules governing client premiums within 30 days after July 1, 1991, including criteria for determining when services to a client must be terminated due to failure to pay a premium.

[For text of subds 13 to 15c, see M.S.1998]

Subd. 16. **Conversion of enrollment.** Upon approval of the elderly waiver amendments described in section 256B.0915, subdivision 1d, persons currently receiving services shall have their eligibility for the elderly waiver program determined under section 256B.0915. Persons currently receiving alternative care services whose income is under the special income standard according to Code of Federal Regulations, title 42, section 435.236, who are eligible for the elderly waiver program shall be transferred to that program and shall receive priority access to elderly waiver slots for six months after implementation of this subdivision, except that persons whose income is above the maintenance needs amount described in section 256B.0915, subdivision 1d, paragraph (a), shall have the option of remaining in the alternative care program. Persons currently enrolled in the alternative care program who are not eligible for the elderly waiver program shall continue to be eligible for the alternative care program. Persons who apply for the alternative care program after approval of the elderly waiver amendments in section 256B.0915, subdivision 1d, whose income is under the special income standard according to Code of Federal Regulations, title 42, section 435.236, are not eligible for alternative care if they would qualify for the elderly waiver, except that persons whose income is above the maintenance needs amount described in section 256B.0915, subdivision 1d, paragraph (a), shall have the option of remaining in the alternative care program.

History: *1999 c 245 art 3 s 13–16*

256B.0914 CONFLICTS OF INTEREST RELATED TO MEDICAID EXPENDITURES.

Subdivision 1. **Definitions.** (a) "Contract" means a written, fully executed agreement for the purchase of goods and services involving a substantial expenditure of Medicaid funding. A contract under a renewal period shall be considered a separate contract.

(b) "Contractor bid or proposal information" means cost or pricing data, indirect costs, and proprietary information marked as such by the bidder in accordance with applicable law.

(c) "Particular expenditure" means a substantial expenditure as defined below, for a specified term, involving specific parties. The renewal of an existing contract for the substantial expenditure of Medicaid funds is considered a separate, particular expenditure from the original contract.

(d) "Source selection information" means any of the following information prepared for use by the state, county, or independent contractor for the purpose of evaluating a bid or proposal to enter into a Medicaid procurement contract, if that information has not been previously made available to the public or disclosed publicly:

(1) bid prices submitted in response to a solicitation for sealed bids, or lists of the bid prices before bid opening;

(2) proposed costs or prices submitted in response to a solicitation, or lists of those proposed costs or prices;

(3) source selection plans;

(4) technical evaluations plans;

(5) technical evaluations of proposals;

(6) cost or price evaluation of proposals;

(7) competitive range determinations that identify proposals that have a reasonable chance of being selected for award of a contract;

(8) rankings of bids, proposals, or competitors;

(9) the reports and evaluations of source selection panels, boards, or advisory councils; and

(10) other information marked as "source selection information" based on a case–by–case determination by the head of the agency, contractor, designees, or the contracting officer that disclosure of the information would jeopardize the integrity or successful completion of the Medicaid procurement to which the information relates.

(e) "Substantial expenditure" and "substantial amounts" mean a purchase of goods or services in excess of $10,000,000 in Medicaid funding under this chapter or chapter 256L.

Subd. 2. **Applicability.** (a) Unless provided otherwise, this section applies to:

(1) any state or local officer, employee, or independent contractor who is responsible for the substantial expenditures of medical assistance or MinnesotaCare funding under this chapter or chapter 256L for which federal Medicaid matching funds are available;

(2) any individual who formerly was such an officer, employee, or independent contractor; and

(3) any partner of such a state or local officer, employee, or independent contractor.

(b) This section is intended to meet the requirements of state participation in the Medicaid program at United States Code, title 42, sections 1396a(a)(4) and 1396u–2(d)(3), which require that states have in place restrictions against conflicts of interest in the Medicaid procurement process, that are at least as stringent as those in effect under United States Code, title 41, section 423, and title 18, sections 207 and 208, as they apply to federal employees.

Subd. 3. **Disclosure of procurement information.** A person described in subdivision 2 may not knowingly disclose contractor bid or proposal information, or source selection information before the award by the state, county, or independent contractor of a Medicaid procurement contract to which the information relates unless the disclosure is otherwise authorized by law. No person, other than as provided by law, shall knowingly obtain contractor bid or proposal information or source selection information before the award of a Medicaid procurement contract to which the information relates.

Subd. 4. **Offers of employment.** When a person described in subdivision 2, paragraph (a), is participating personally and substantially in a Medicaid procurement for a contract contacts or is contacted by a person who is a bidder or offeror in the same procurement regarding possible employment outside of the entity by which the person is currently employed, the person must:

(1) report the contact in writing to the person's supervisor and employer's ethics officer; and

(2) either:

(i) reject the possibility of employment with the bidder or offeror; or

(ii) be disqualified from further participation in the procurement until the bidder or offeror is no longer involved in that procurement, or all discussions with the bidder or offeror regarding possible employment have terminated without an arrangement for employment. A

bidder or offeror may not engage in employment discussions with an official who is subject to this subdivision, until the bidder or offeror is no longer involved in that procurement.

Subd. 5. **Acceptance of compensation by a former official.** (a) A former official of the state or county, or a former independent contractor, described in subdivision 2 may not accept compensation from a Medicaid contractor of a substantial expenditure as an employee, officer, director, or consultant of the contractor within one year after the former official or independent contractor:

(1) served as the procuring contracting officer, the source selection authority, a member of the source selection evaluation board, or the chief of a financial or technical evaluation team in a procurement in which the contractor was selected for award;

(2) served as the program manager, deputy program manager, or administrative contracting officer for a contract awarded to the contractor; or

(3) personally made decisions for the state, county, or independent contractor to:

(i) award a contract, subcontract, modification of a contract or subcontract, or a task order or delivery order to the contractor;

(ii) establish overhead or other rates applicable to a contract or contracts with the contractor;

(iii) approve issuance of a contract payment or payments to the contractor; or

(iv) pay or settle a claim with the contractor.

(b) Paragraph (a) does not prohibit a former official of the state, county, or independent contractor from accepting compensation from any division or affiliate of a contractor not involved in the same or similar products or services as the division or affiliate of the contractor that is responsible for the contract referred to in paragraph (a), clause (1), (2), or (3).

(c) A contractor shall not provide compensation to a former official knowing that the former official is accepting that compensation in violation of this subdivision.

Subd. 6. **Permanent restrictions on representation and communication.** (a) A person described in subdivision 2, after termination of his or her service with state, county, or independent contractor, is permanently restricted from knowingly making, with the intent to influence, any communication to or appearance before an officer or employee of a department, agency, or court of the United States, the state of Minnesota and its counties in connection with a particular expenditure:

(1) in which the United States, the state of Minnesota, or a Minnesota county is a party or has a direct and substantial interest;

(2) in which the person participated personally and substantially as an officer, employee, or independent contractor; and

(3) which involved a specific party or parties at the time of participation.

(b) For purposes of this subdivision and subdivisions 7 and 9, "participated" means an action taken through decision, approval, disapproval, recommendation, the rendering of advice, investigation, or other such action.

Subd. 7. **Two-year restrictions on representation and communication.** No person described in subdivision 2, within two years after termination of service with the state, county, or independent contractor, shall knowingly make, with the intent to influence, any communication to or appearance before any officer or employee of any government department, agency, or court in connection with a particular expenditure:

(1) in which the United States, the state of Minnesota, or a Minnesota county is a party or has a direct and substantial interest;

(2) which the person knows or reasonably should know was actually pending under the official's responsibility as an officer, employee, or independent contractor within one year before the termination of the official's service with the state, county, or independent contractor; and

(3) which involved a specific party or parties at the time the expenditure was pending.

Subd. 8. **Exceptions to permanent and two-year restrictions on representation and communication.** Subdivisions 6 and 7 do not apply to:

(1) communications or representations made in carrying out official duties on behalf of the United States, the state of Minnesota or local government, or as an elected official of the state or local government;

(2) communications made solely for the purpose of furnishing scientific or technological information; or

(3) giving testimony under oath. A person subject to subdivisions 6 and 7 may serve as an expert witness in that matter, without restriction, for the state, county, or independent contractor. Under court order, a person subject to subdivisions 6 and 7 may serve as an expert witness for others. Otherwise, the person may not serve as an expert witness in that matter.

Subd. 9. **Waiver.** The commissioner of human services, or the governor in the case of the commissioner, may grant a waiver of a restriction in subdivisions 6 and 7 if he or she determines that a waiver is in the public interest and that the services of the officer or employee are critically needed for the benefit of the state or county government.

Subd. 10. **Acts affecting a personal financial interest.** A person described in subdivision 2, paragraph (a), clause (1), who participates in a particular expenditure in which the person has knowledge or has a financial interest, is subject to the penalties in subdivision 12. For purposes of this subdivision, "financial interest" also includes the financial interest of a spouse, minor child, general partner, organization in which the officer or employee is serving as an officer, director, trustee, general partner, or employee, or any person or organization with whom the individual is negotiating or has any arrangement concerning prospective employment.

Subd. 11. **Exceptions to prohibitions regarding financial interest.** Subdivision 10 does not apply if:

(1) the person first advises the person's supervisor and the employer's ethics officer regarding the nature and circumstances of the particular expenditure and makes full disclosure of the financial interest and receives in advance a written determination made by the commissioner of human services, or the governor in the case of the commissioner, that the interest is not so substantial as to likely affect the integrity of the services which the government may expect from the officer, employee, or independent contractor;

(2) the financial interest is listed as an exemption at Code of Federal Regulations, title 5, sections 2640.201 to 2640.203, as too remote or inconsequential to affect the integrity of the services of the office, employee, or independent contractor to which the requirement applies.

Subd. 12. **Criminal penalties.** (a) A person who violates subdivisions 3 to 5 for the purpose of either exchanging the information covered by this section for anything of value, or for obtaining or giving anyone a competitive advantage in the award of a Medicaid contract, may be sentenced to imprisonment for not more than five years or payment of a fine of not more than $50,000 for each violation, or the amount of compensation which the person received or offered for the prohibited conduct, whichever is greater, or both.

(b) A person who violates a provision of subdivisions 6 to 11 may be sentenced to imprisonment for not more than one year or payment of a fine of not more than $50,000 for each violation or the amount of compensation which the person received or offered for the prohibited conduct, whichever amount is greater, or both. A person who willfully engages in conduct in violation of subdivisions 6 to 11 may be sentenced to imprisonment for not more than five years or to payment of a fine of not more than $50,000 for each violation or the amount of compensation which the person received or offered for the prohibited conduct, whichever amount is greater, or both.

(c) Nothing in this section precludes prosecution under other laws such as section 609.43.

Subd. 13. **Civil penalties and injunctive relief.** (a) The Minnesota attorney general may bring a civil action in Ramsey county district court against a person who violates this section. Upon proof of such conduct by a preponderance of evidence, the person is subject to a civil penalty. An individual who violates this section is subject to a civil penalty of not more than $50,000 for each violation plus twice the amount of compensation which the individual received or offered for the prohibited conduct. An organization that violates this section is subject to a civil penalty of not more than $500,000 for each violation plus twice the amount of compensation which the organization received or offered for the prohibited conduct.

(b) If the Minnesota attorney general has reason to believe that a person is engaging in conduct in violation of this section, the attorney general may petition the Ramsey county district court for an order prohibiting that person from engaging in such conduct. The court may issue an order prohibiting that person from engaging in such conduct if the court finds that the conduct constitutes such a violation. The filing of a petition under this subdivision does not preclude any other remedy which is available by law.

Subd. 14. **Administrative actions.** (a) If a state agency, local agency, or independent contractor receives information that a contractor or a person has violated this section, the state agency, local agency, or independent contractor may:

(1) cancel the procurement if a contract has not already been awarded;

(2) rescind the contract; or

(3) initiate suspension or debarment proceedings according to applicable state or federal law.

(b) If the contract is rescinded, the state agency, local agency, or independent contractor is entitled to recover, in addition to any penalty prescribed by law, the amount expended under the contract.

(c) This section does not:

(1) restrict the disclosure of information to or from any person or class of persons authorized to receive that information;

(2) restrict a contractor from disclosing the contractor's bid or proposal information or the recipient from receiving that information;

(3) restrict the disclosure or receipt of information relating to a Medicaid procurement after it has been canceled by the state agency, county agency, or independent contractor before the contract award unless the agency or independent contractor plans to resume the procurement; or

(4) limit the applicability of any requirements, sanctions, contract penalties, and remedies established under any other law or regulation.

(d) No person may file a protest against the award or proposed award of a Medicaid contract alleging a violation of this section unless that person reported the information the person believes constitutes evidence of the offense to the applicable state agency, local agency, or independent contractor responsible for the procurement. The report must be made no later than 14 days after the person first discovered the possible violation.

History: *1999 c 245 art 4 s 60*

256B.0916 EXPANSION OF HOME AND COMMUNITY–BASED SERVICES; MANAGEMENT AND ALLOCATION RESPONSIBILITIES.

Subdivision 1. **Reduction of waiting list.** (a) The legislature recognizes that as of January 1, 1999, 3,300 persons with mental retardation or related conditions have been screened and determined eligible for the home and community–based waiver services program for persons with mental retardation or related conditions. Many wait for several years before receiving service.

(b) The waiting list for this program shall be reduced or eliminated by June 30, 2003. In order to reduce the number of eligible persons waiting for identified services provided through the home and community–based waiver for persons with mental retardation or related conditions, funding shall be increased to add 100 additional eligible persons each year beyond the February 1999 medical assistance forecast.

(c) The commissioner shall allocate resources in such a manner as to use all resources budgeted for the home and community–based waiver for persons with mental retardation or related conditions according to the priorities listed in subdivision 2, paragraph (b), and then to serve other persons on the waiting list. Resources allocated for a fiscal year to serve persons affected by public and private sector ICF/MR closures, but not expected to be expended for that purpose, must be reallocated within that fiscal year to serve other persons on the waiting list, and the number of waiver diversion slots shall be adjusted accordingly.

(d) For fiscal year 2001, at least one–half of the increase in funding over the previous year provided in the February 1999 medical assistance forecast for the home and communi-

ty–based waiver for persons with mental retardation and related conditions, including changes made by the 1999 legislature, must be used to serve persons who are not affected by public and private sector ICF/MR closures.

Subd. 2. **Distribution of funds; partnerships.** (a) Beginning with fiscal year 2000, the commissioner shall distribute all funding available for home and community–based waiver services for persons with mental retardation or related conditions to individual counties or to groups of counties that form partnerships to jointly plan, administer, and authorize funding for eligible individuals. The commissioner shall encourage counties to form partnerships that have a sufficient number of recipients and funding to adequately manage the risk and maximize use of available resources.

(b) Counties must submit a request for funds and a plan for administering the program as required by the commissioner. The plan must identify the number of clients to be served, their ages, and their priority listing based on:

(1) requirements in Minnesota Rules, part 9525.1880;

(2) unstable living situations due to the age or incapacity of the primary caregiver;

(3) the need for services to avoid out–of–home placement of children; and

(4) the need to serve persons affected by private sector ICF/MR closures.

The plan must also identify changes made to improve services to eligible persons and to improve program management.

(c) In allocating resources to counties, priority must be given to groups of counties that form partnerships to jointly plan, administer, and authorize funding for eligible individuals and to counties determined by the commissioner to have sufficient waiver capacity to maximize resource use.

(d) Within 30 days after receiving the county request for funds and plans, the commissioner shall provide a written response to the plan that includes the level of resources available to serve additional persons.

(e) Counties are eligible to receive medical assistance administrative reimbursement for administrative costs under criteria established by the commissioner.

Subd. 3. **Failure to develop partnerships or submit a plan.** (a) By October 1 of each year the commissioner shall notify the county board if any county determined by the commissioner to have insufficient capacity to maximize use of available resources fails to develop a partnership with other counties or fails to submit a plan as required in subdivision 2. The commissioner shall provide needed technical assistance to a county or group of counties that fails to form a partnership or submit a plan. If a county has not joined a county partnership or submitted a plan within 30 days following the notice by the commissioner of its failure, the commissioner shall require and assist that county to develop a plan or contract with another county or group of counties to plan and administer the waiver services program in that county.

(b) Counties may request technical assistance, management information, and administrative support from the commissioner at any time. The commissioner shall respond to county requests within 30 days. Priority shall be given to activities that support the administrative needs of newly formed county partnerships.

Subd. 4. **Allowed reserve.** Counties or groups of counties participating in partnerships that have submitted a plan under this section may develop an allowed reserve amount to meet crises and other unmet needs of current home and community–based waiver recipients. The amount of the allowed reserve shall be a county specific amount based upon documented past experience and projected need for the coming year described in an allowed reserve plan submitted for approval to the commissioner with the allocation request for the fiscal year.

Subd. 5. **Priorities for reassignment of resources and approval of increased capacity.** In order to maximize the number of persons served with waiver funds, the commissioner shall monitor county utilization of allocated resources and, as appropriate, reassign resources not utilized and approve increased capacity within available county allocations. Priority consideration for reassignment of resources and approval of increased capacity shall be given to counties with sufficient capacity and counties that form partnerships. In addition to the priorities listed in Minnesota Rules, part 9525.1880, the commissioner shall also give

priority consideration to persons whose living situations are unstable due to the age or incapacity of the primary caregiver and to children to avoid out–of–home placement.

Subd. 6. **Waiver request.** (a) The commissioner shall submit to the federal Health Care Financing Administration by September 1, 1999, a request for a waiver to include an option that would allow waiver service recipients to directly receive 95 percent of the funds that would be allocated to individuals based on written county criteria and procedures approved by the commissioner for the purchase of services to meet their long–term care needs. The waiver request must include a provision requiring recipients who receive funds directly to provide to the commissioner annually, a description of the type of services used, the amount paid for the services purchased, and the amount of unspent funds.

(b) The commissioner, in cooperation with county representatives, waiver service providers, recipients, recipients' families, legal guardians, and advocacy groups, shall develop criteria for:

(1) eligibility to receive funding directly;

(2) determination of the amount of funds made available to each eligible person based on need; and

(3) the accountability required of persons directly receiving funds.

(c) If this waiver is approved and implemented, any unspent money from the waiver services allocation, including the five percent not directly allocated to recipients and any unspent portion of the money that is directly allocated, shall be used to meet the needs of other eligible persons waiting for services funded through the waiver.

(d) The commissioner, in consultation with county social services agencies, waiver services providers, recipients, recipients' families, legal guardians, and advocacy groups shall evaluate the effectiveness of this option within two years of its implementation.

Subd. 7. **Annual report by commissioner.** Beginning October 1, 1999, and each October 1 thereafter, the commissioner shall issue an annual report on county and state use of available resources for the home and community–based waiver for persons with mental retardation or related conditions. For each county or county partnership, the report shall include:

(1) the amount of funds allocated but not used;

(2) the county specific allowed reserve amount approved and used;

(3) the number, ages, and living situations of individuals screened and waiting for services;

(4) the urgency of need for services to begin within one, two, or more than two years for each individual;

(5) the services needed;

(6) the number of additional persons served by approval of increased capacity within existing allocations;

(7) results of action by the commissioner to streamline administrative requirements and improve county resource management; and

(8) additional action that would decrease the number of those eligible and waiting for waivered services.

The commissioner shall specify intended outcomes for the program and the degree to which these specified outcomes are attained.

Subd. 8. **Financial information by county.** The commissioner shall make available to interested parties, upon request, financial information by county including the amount of resources allocated for the home and community–based waiver for persons with mental retardation and related conditions, the resources committed, the number of persons screened and waiting for services, the type of services requested by those waiting, and the amount of allocated resources not committed.

Subd. 9. **Legal representative participation exception.** The commissioner, in cooperation with representatives of counties, service providers, service recipients, family members, legal representatives and advocates, shall develop criteria to allow legal representatives to be reimbursed for providing specific support services to meet the person's needs when a

plan which assures health and safety has been agreed upon and carried out by the legal representative, the person, and the county. Legal representatives providing support under consumer–directed community support services pursuant to section 256B.092, subdivision 4, or the consumer support grant program pursuant to section 256B.092, subdivision 7, shall not be considered to have a direct or indirect service provider interest under section 256B.092, subdivision 7, if a health and safety plan which meets the criteria established has been agreed upon and implemented. By October 1, 1999, the commissioner shall submit, for federal approval, amendments to allow legal representatives to provide support and receive reimbursement under the consumer–directed community support services section of the home and community–based waiver plan.

History: *1999 c 245 art 4 s 61*

256B.0917 SENIORS' AGENDA FOR INDEPENDENT LIVING (SAIL) PROJECTS FOR A NEW LONG–TERM CARE STRATEGY.

[For text of subds 1 to 7, see M.S.1998]

Subd. 8. **Living–at–home/block nurse program grant.** (a) The organization awarded the contract under subdivision 7, shall develop and administer a grant program to establish or expand up to 33 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. At least one–half of the programs must be in counties outside the seven–county metropolitan area. 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 organization awarded the contract under subdivision 7 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;

(3) are located in counties adjacent to, or are located in, counties with existing living–at–home/block nurse programs; and

(4) meet other criteria established by LAH/BN, Inc., in consultation with the commissioner.

(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 four–year periods, and the base amount shall not exceed $80,000 per applicant for the grant period. 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 assistance. Subject to the availability of funding, grants and grant renewals awarded or entered into on or after July 1, 1997, shall be renewed by LAH/BN, Inc. every four years, unless LAH/BN, Inc. determines that the grant recipient has not satisfactorily operated the living–at–home/block

nurse program in compliance with the requirements of paragraphs (b) and (d). Grants provided to living–at–home/block nurse programs under this paragraph may be used for both program development and the delivery of services.

(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.

[For text of subds 9 to 12, see M.S.1998]

History: *1999 c 245 art 4 s 62*

256B.0928 STATEWIDE CAREGIVER SUPPORT AND RESPITE CARE PROJECT.

The commissioner shall establish and maintain a statewide caregiver support and respite care project. The project 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 resource center;

(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.

History: *1999 c 86 art 2 s 5*

256B.094 CHILD WELFARE TARGETED CASE MANAGEMENT SERVICES.

[For text of subds 1 and 2, see M.S.1998]

Subd. 3. **Coordination and provision of services.** (a) In a county or reservation where a prepaid medical assistance provider has contracted under section 256B.031 or 256B.69 to provide mental health services, the case management provider shall coordinate with the prepaid provider to ensure that all necessary mental health services required under the contract are provided to recipients of case management services.

(b) When the case management provider determines that a prepaid provider is not providing mental health services as required under the contract, the case management provider shall assist the recipient to appeal the prepaid provider's denial pursuant to section 256.045, and may make other arrangements for provision of the covered services.

(c) The case management provider may bill the provider of prepaid health care services for any mental health services provided to a recipient of case management services which the

county or tribal social services arranges for or provides and which are included in the prepaid provider's contract, and which were determined to be medically necessary as a result of an appeal pursuant to section 256.045. The prepaid provider must reimburse the mental health provider, at the prepaid provider's standard rate for that service, for any services delivered under this subdivision.

(d) If the county or tribal social services has not obtained prior authorization for this service, or an appeal results in a determination that the services were not medically necessary, the county or tribal social services may not seek reimbursement from the prepaid provider.

[For text of subd 4, see M.S.1998]

Subd. 5. **Case manager.** To provide case management services, a case manager must be employed or contracted by and authorized by the case management provider to provide case management services and meet all requirements under section 256F.10.

Subd. 6. **Medical assistance reimbursement of case management services.** (a) Medical assistance reimbursement for services under this section shall be made on a monthly basis. Payment is based on face–to–face or telephone contacts between the case manager and the client, client's family, primary caregiver, legal representative, or other relevant person identified as necessary to the development or implementation of the goals of the individual service plan regarding the status of the client, the individual service plan, or the goals for the client. These contacts must meet the minimum standards in clauses (1) and (2):

(1) there must be a face–to–face contact at least once a month except as provided in clause (2); and

(2) for a client placed outside of the county of financial responsibility in an excluded time facility under section 256G.02, subdivision 6, or through the Interstate Compact on the Placement of Children, section 260.851, and the placement in either case is more than 60 miles beyond the county boundaries, there must be at least one contact per month and not more than two consecutive months without a face–to–face contact.

(b) Except as provided under paragraph (c), the payment rate is established using time study data on activities of provider service staff and reports required under sections 245.482, 256.01, subdivision 2, paragraph (17), and 256E.08, subdivision 8.

(c) Payments for tribes may be made according to section 256B.0625 for child welfare targeted case management provided by Indian health services and facilities operated by a tribe or tribal organization.

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

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

Separate payment rates may be established for different groups of providers to maximize reimbursement as determined by the commissioner. The payment rate will be reviewed annually and revised periodically to be consistent with the most recent time study and other data. Payment for services will be made upon submission of a valid claim and verification of proper documentation described in subdivision 7. Federal administrative revenue earned through the time study, or under paragraph (c), shall be distributed according to earnings, to

counties, reservations, or groups of counties or reservations which have the same payment rate under this subdivision, and to the group of counties or reservations which are not certified providers under section 256F.10. The commissioner shall modify the requirements set out in Minnesota Rules, parts 9550.0300 to 9550.0370, as necessary to accomplish this.

[For text of subds 7 and 8, see M.S.1998]

History: *1999 c 139 art 4 s 2; 1999 c 245 art 8 s 6–8*

256B.0945 RESIDENTIAL SERVICES FOR CHILDREN WITH SEVERE EMOTIONAL DISTURBANCE.

Subdivision 1. **Provider qualifications.** Counties must arrange to provide residential services for children with severe emotional disturbance according to section 245.4882 and this section. Services must be provided by a facility that is licensed according to section 245.4882 and administrative rules promulgated thereunder, and under contract with the county. Facilities providing services under subdivision 2, paragraph (a), must be accredited as a psychiatric facility by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation. Accreditation is not required for facilities providing services under subdivision 2, paragraph (b).

Subd. 2. **Covered services.** All services must be included in a child's individualized treatment or collaborative family service plan as defined in chapter 245.

(a) For facilities that are institutions for mental diseases according to statute and regulation or are not institutions for mental diseases but choose to provide services under this paragraph, medical assistance covers the full contract rate, including room and board if the services meet the requirements of Code of Federal Regulations, title 42, section 440.160.

(b) For facilities that are not institutions for mental diseases according to federal statute and regulation and are not providing services under paragraph (a), medical assistance covers mental health related services that are required to be provided by a residential facility under section 245.4882 and administrative rules promulgated thereunder, except for room and board.

Subd. 3. **Centralized disbursement of medical assistance payments.** Notwithstanding section 256B.041, county payments for the cost of residential services provided under this section shall not be made to the state treasurer.

Subd. 4. **Payment rates.** (a) Notwithstanding sections 256.025, subdivision 2; 256B.19; and 256B.041, payments to counties for residential services provided by a residential facility shall only be made of federal earnings for services provided under this section, and the nonfederal share of costs for services provided under this section shall be paid by the county from sources other than federal funds or funds used to match other federal funds. Total annual payments for federal earnings shall not exceed the federal medical assistance percentage matching rate multiplied by the total county expenditures for services provided under section 245.4882 for either (1) the calendar year 1999 or (2) the average annual expenditures for the calendar years 1995 to 1999, whichever is greater. Payment to counties for services provided according to subdivision 2, paragraph (a), shall be the federal share of the contract rate. Payment to counties for services provided according to subdivision 2, paragraph (b), shall be a proportion of the per day contract rate that relates to rehabilitative mental health services and shall not include payment for costs or services that are billed to the IV–E program as room and board.

(b) Annual earnings that exceed a county's limit as established under paragraph (a) shall be retained by the commissioner and managed as grants for community–based children's mental health services under section 245.4886. The commissioner may target these grant funds as necessary to reduce reliance on residential treatment of children with severe emotional disturbance.

(c) The commissioner shall set aside a portion of the federal funds earned under this section to cover the state costs of two staff positions and support costs necessary in administering this section. Any unexpended funds from the set–aside shall be distributed to the counties in proportion to their earnings under this section.

Subd. 5. **Quality measures.** Counties must collect and report to the commissioner information on outcomes for services provided under this section using standardized tools that measure functioning, living stability, and parent and child satisfaction consistent with the goals of sections 245.4876, subdivision 1, and 256F.01. The commissioner shall designate standardized tools to be used and shall collect and analyze individualized outcome data on a statewide basis and report to the legislature by December 1, 2003. The commissioner shall provide standardized tools that measure child and adolescent functional assessment for intake and discharge, child behavior, residential living environment and placement stability, and satisfaction for youth and family members.

Subd. 6. **Federal earnings.** Use of new federal funding earned from services provided under this section is limited to:

(1) increasing prevention and early intervention and supportive services to meet the mental health and child welfare needs of the children and families in the system of care;

(2) replacing reductions in federal IV–E reimbursement resulting from new medical assistance coverage; and

(3) paying the nonfederal share of additional provider costs due to accreditation and new program standards necessary for Medicaid reimbursement.

For purposes of this section, early intervention and supportive services include alternative responses to child maltreatment reports under chapter 626 and services outlined in sections 245.4875, subdivision 2, children's mental health, and 256F.05, subdivision 8, family preservation services.

Subd. 7. **Maintenance of effort.** (a) Counties that receive payment under this section must maintain a level of expenditures such that each year's county expenditures for early intervention and supportive services is at least equal to that county's average expenditures for those services for calendar years 1998 and 1999. For purposes of this section, "county expenditures" are the total expenditures for those services minus the state and federal revenues specifically designated for these services.

(b) The commissioner may waive the requirements in paragraph (a) if any of the conditions specified in section 256F.13, subdivision 1, paragraph (a), clause (4), items (i) to (iv), are met.

Subd. 8. **Reports.** The commissioner shall review county expenditures annually using reports required under sections 245.482; 256.01, subdivision 2, clause (17); and 256E.08, subdivision 8, to ensure that counties meet their obligation under subdivision 7, and that the base level of expenditures for mental health and child welfare early intervention and family support services and children's mental health residential treatment is continued from sources other than federal funds earned under this section.

Subd. 9. **Sanctions.** The commissioner may suspend, reduce, or terminate the federal reimbursement to a county that does not meet one or all of the requirements of this section.

Subd. 10. **Recommendations.** The commissioner shall provide recommendations to the legislature by January 15, 2000, regarding any amendments to this section that may be necessary or advisable prior to implementation.

History: *1999 c 245 art 8 s 9*

NOTE: This section, as added by Laws 1999, chapter 245, article 8, section 9, is effective July 1, 2000. Laws 1999, chapter 245, article 8, section 87.

256B.0951 QUALITY ASSURANCE COMMISSION.

Subdivision 1. **Membership.** The region 10 quality assurance commission is established. The commission consists of at least 14 but not more than 21 members as follows: at least three but not more than five members representing advocacy organizations; at least three but not more than five members representing consumers, families, and their legal representatives; at least three but not more than five members representing service providers; at least three but not more than five members representing counties; and the commissioner of human services or the commissioner's designee. Initial membership of the commission shall be recruited and approved by the region 10 stakeholders group. Prior to approving the commission's membership, the stakeholders group shall provide to the commissioner a list of the

membership in the stakeholders group, as of February 1, 1997, a brief summary of meetings held by the group since July 1, 1996, and copies of any materials prepared by the group for public distribution. The first commission shall establish membership guidelines for the transition and recruitment of membership for the commission's ongoing existence. Members of the commission who do not receive a salary or wages from an employer for time spent on commission duties may receive a per diem payment when performing commission duties and functions. All members may be reimbursed for expenses related to commission activities. Notwithstanding the provisions of section 15.059, subdivision 5, the commission expires on June 30, 2001.

[For text of subd 2, see M.S.1998]

Subd. 3. **Commission duties.** (a) By October 1, 1997, the commission, in cooperation with the commissioners of human services and health, shall do the following: (1) approve an alternative quality assurance licensing system based on the evaluation of outcomes; (2) approve measurable outcomes in the areas of health and safety, consumer evaluation, education and training, providers, and systems that shall be evaluated during the alternative licensing process; and (3) establish variable licensure periods not to exceed three years based on outcomes achieved. For purposes of this subdivision, "outcome" means the behavior, action, or status of a person that can be observed or measured and can be reliably and validly determined.

(b) By January 15, 1998, the commission shall approve, in cooperation with the commissioner of human services, a training program for members of the quality assurance teams established under section 256B.0952, subdivision 4.

(c) The commission and the commissioner shall establish an ongoing review process for the alternative quality assurance licensing system. The review shall take into account the comprehensive nature of the alternative system, which is designed to evaluate the broad spectrum of licensed and unlicensed entities that provide services to clients, as compared to the current licensing system.

(d) The commission shall contract with an independent entity to conduct a financial review of the alternative quality assurance pilot project. The review shall take into account the comprehensive nature of the alternative system, which is designed to evaluate the broad spectrum of licensed and unlicensed entities that provide services to clients, as compared to the current licensing system. The review shall include an evaluation of possible budgetary savings within the department of human services as a result of implementation of the alternative quality assurance pilot project. If a federal waiver is approved under subdivision 7, the financial review shall also evaluate possible savings within the department of health. This review must be completed by December 15, 2000.

(e) The commission shall submit a report to the legislature by January 15, 2001, on the results of the review process for the alternative quality assurance pilot project, a summary of the results of the independent financial review, and a recommendation on whether the pilot project should be extended beyond June 30, 2001.

[For text of subds 4 to 7, see M.S.1998]

History: *1999 c 245 art 4 s 63,64*

256B.0955 DUTIES OF THE COMMISSIONER OF HUMAN SERVICES.

(a) Effective July 1, 1998, the commissioner of human services shall delegate authority to perform licensing functions and activities, in accordance with section 245A.16, to counties participating in the alternative licensing system. The commissioner shall not license or reimburse a facility, program, or service for persons with developmental disabilities in a county that participates in the alternative licensing system if the commissioner has received from the appropriate county notification that the facility, program, or service has been reviewed by a quality assurance team and has failed to qualify for licensure.

(b) The commissioner may conduct random licensing inspections based on outcomes adopted under section 256B.0951 at facilities, programs, and services governed by the alternative licensing system. The role of such random inspections shall be to verify that the alternative licensing system protects the safety and well–being of consumers and maintains the availability of high–quality services for persons with developmental disabilities.

(c) The commissioner shall provide technical assistance and support or training to the alternative licensing system pilot project.

History: *1999 c 245 art 4 s 65*

256B.37 PRIVATE INSURANCE POLICIES, CAUSES OF ACTION.

[For text of subd 1, see M.S.1998]

Subd. 2. **Civil action for recovery.** To recover under this section, the attorney general may institute or join a civil action to enforce the subrogation rights of the commissioner established under this section.

Any prepaid health plan providing services under sections 256B.69, 256D.03, subdivision 4, paragraph (d), and 256L.12; children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; nursing homes under the alternative payment demonstration project under section 256B.434; or the county–based purchasing entity providing services under section 256B.692 may retain legal representation to enforce the subrogation rights created under this section or, if no action has been brought, may initiate and prosecute an independent action on their behalf against a person, firm, or corporation that may be liable to the person to whom the care or payment was furnished.

[For text of subds 3 to 6, see M.S.1998]

History: *1999 c 245 art 4 s 66,68*

256B.431 RATE DETERMINATION.

[For text of subds 1 to 2h, see M.S.1998]

Subd. 2i. **Operating costs after July 1, 1988.** (a) **Other operating cost limits.** For rate years beginning on or after July 1, 1989, the adjusted other operating cost limits must be indexed as in Minnesota Rules, part 9549.0056, subparts 3 and 4. For the rate period beginning October 1, 1992, and for rate years beginning after June 30, 1993, the amount of the surcharge under section 256.9657, subdivision 1, shall be included in the plant operations and maintenance operating cost category. The surcharge shall be an allowable cost for the purpose of establishing the payment rate.

(b) **Care–related operating cost limits.** For rate years beginning on or after July 1, 1989, the adjusted care–related limits must be indexed as in Minnesota Rules, part 9549.0056, subparts 1 and 2.

(c) **Salary adjustment per diem.** Effective July 1, 1998, to June 30, 2000, the commissioner shall make available the salary adjustment per diem calculated in clause (1) or (2) to the total operating cost payment rate of each nursing facility reimbursed under this section or section 256B.434. The salary adjustment per diem for each nursing facility must be determined as follows:

(1) For each nursing facility that reports salaries for registered nurses, licensed practical nurses, and aides, orderlies and attendants separately, the commissioner shall determine the salary adjustment per diem by multiplying the total salaries, payroll taxes, and fringe benefits allowed in each operating cost category, except management fees and administrator and central office salaries and the related payroll taxes and fringe benefits, by 3.0 percent and then dividing the resulting amount by the nursing facility's actual resident days.

(2) For each nursing facility that does not report salaries for registered nurses, licensed practical nurses, aides, orderlies, and attendants separately, the salary adjustment per diem is the weighted average salary adjustment per diem increase determined under clause (1).

(3) A nursing facility may apply for the salary adjustment per diem calculated under clauses (1) and (2). The application must be made to the commissioner and contain a plan by which the nursing facility will distribute the salary adjustment to employees of the nursing facility. In order to apply for a salary adjustment, a nursing facility reimbursed under section 256B.434, must report the information required by clause (1) or (2) in the application, in the manner specified by the commissioner. For nursing facilities in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative, after July 1, 1998, may constitute the plan for the salary distribution. The commissioner shall review the plan to ensure that the salary adjustment per diem is used solely to increase the compensation of nursing home facility employees. To be eligible, a facility must submit its plan for the salary distribution by December 31, 1998. If a facility's plan for salary distribution is effective for its employees after July 1, 1998, the salary adjustment cost per diem shall be effective the same date as its plan.

(4) Additional costs incurred by nursing facilities as a result of this salary adjustment are not allowable costs for purposes of the September 30, 1998, cost report.

(d) **New base year.** The commissioner shall establish a new base year for the reporting years ending September 30, 1991, and September 30, 1992. In establishing a new base year, the commissioner must take into account:

(1) statutory changes made in geographic groups;

(2) redefinitions of cost categories; and

(3) reclassification, pass–through, or exemption of certain costs.

[For text of subds 2j to 16, see M.S.1998]

Subd. 17. **Special provisions for moratorium exceptions.** (a) Notwithstanding Minnesota Rules, part 9549.0060, subpart 3, for rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, a nursing facility that (1) has completed a construction project approved under section 144A.071, subdivision 4a, clause (m); (2) has completed a construction project approved under section 144A.071, subdivision 4a, and effective after June 30, 1995; or (3) has completed a renovation, replacement, or upgrading project approved under the moratorium exception process in section 144A.073 shall be reimbursed for costs directly identified to that project as provided in subdivision 16 and this subdivision.

(b) Notwithstanding Minnesota Rules, part 9549.0060, subparts 5, item A, subitems (1) and (3), and 7, item D, allowable interest expense on debt shall include:

(1) interest expense on debt related to the cost of purchasing or replacing depreciable equipment, excluding vehicles, not to exceed six percent of the total historical cost of the project; and

(2) interest expense on debt related to financing or refinancing costs, including costs related to points, loan origination fees, financing charges, legal fees, and title searches; and issuance costs including bond discounts, bond counsel, underwriter's counsel, corporate counsel, printing, and financial forecasts. Allowable debt related to items in this clause shall not exceed seven percent of the total historical cost of the project. To the extent these costs are financed, the straight–line amortization of the costs in this clause is not an allowable cost; and

(3) interest on debt incurred for the establishment of a debt reserve fund, net of the interest earned on the debt reserve fund.

(c) Debt incurred for costs under paragraph (b) is not subject to Minnesota Rules, part 9549.0060, subpart 5, item A, subitem (5) or (6).

(d) The incremental increase in a nursing facility's rental rate, determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section, resulting from the acquisition of

allowable capital assets, and allowable debt and interest expense under this subdivision shall be added to its property–related payment rate and shall be effective on the first day of the month following the month in which the moratorium project was completed.

(e) Notwithstanding subdivision 3f, paragraph (a), for rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, the replacement–costs–new per bed limit to be used in Minnesota Rules, part 9549.0060, subpart 4, item B, for a nursing facility that has completed a renovation, replacement, or upgrading project that has been approved under the moratorium exception process in section 144A.073, or that has completed an addition to or replacement of buildings, attached fixtures, or land improvements for which the total historical cost exceeds the lesser of $150,000 or ten percent of the most recent appraised value, must be $47,500 per licensed bed in multiple–bed rooms and $71,250 per licensed bed in a single–bed room. These amounts must be adjusted annually as specified in subdivision 3f, paragraph (a), beginning January 1, 1993.

(f) A nursing facility that completes a project identified in this subdivision and, as of April 17, 1992, has not been mailed a rate notice with a special appraisal for a completed project, or completes a project after April 17, 1992, but before September 1, 1992, may elect either to request a special reappraisal with the corresponding adjustment to the property–related payment rate under the laws in effect on June 30, 1992, or to submit their capital asset and debt information after that date and obtain the property–related payment rate adjustment under this section, but not both.

(g) For purposes of this paragraph, a total replacement means the complete replacement of the nursing facility's physical plant through the construction of a new physical plant or the transfer of the nursing facility's license from one physical plant location to another. For total replacement projects completed on or after July 1, 1992, the commissioner shall compute the incremental change in the nursing facility's rental per diem, for rate years beginning on or after July 1, 1995, by replacing its appraised value, including the historical capital asset costs, and the capital debt and interest costs with the new nursing facility's allowable capital asset costs and the related allowable capital debt and interest costs. If the new nursing facility has decreased its licensed capacity, the aggregate investment per bed limit in subdivision 3a, paragraph (d), shall apply. If the new nursing facility has retained a portion of the original physical plant for nursing facility usage, then a portion of the appraised value prior to the replacement must be retained and included in the calculation of the incremental change in the nursing facility's rental per diem. For purposes of this part, the original nursing facility means the nursing facility prior to the total replacement project. The portion of the appraised value to be retained shall be calculated according to clauses (1) to (3):

(1) The numerator of the allocation ratio shall be the square footage of the area in the original physical plant which is being retained for nursing facility usage.

(2) The denominator of the allocation ratio shall be the total square footage of the original nursing facility physical plant.

(3) Each component of the nursing facility's allowable appraised value prior to the total replacement project shall be multiplied by the allocation ratio developed by dividing clause (1) by clause (2).

In the case of either type of total replacement as authorized under section 144A.071 or 144A.073, the provisions of this subdivision shall also apply. For purposes of the moratorium exception authorized under section 144A.071, subdivision 4a, paragraph (s), if the total replacement involves the renovation and use of an existing health care facility physical plant, the new allowable capital asset costs and related debt and interest costs shall include first the allowable capital asset costs and related debt and interest costs of the renovation, to which shall be added the allowable capital asset costs of the existing physical plant prior to the renovation, and if reported by the facility, the related allowable capital debt and interest costs.

(h) Notwithstanding Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), for a total replacement, as defined in paragraph (g), authorized under section 144A.071 or 144A.073 after July 1, 1999, the replacement–costs–new per bed limit shall be $74,280 per licensed bed in multiple–bed rooms, $92,850 per licensed bed in semiprivate rooms with a fixed partition separating the resident beds, and $111,420 per licensed bed in single rooms. Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), does not apply. These

amounts must be adjusted annually as specified in subdivision 3f, paragraph (a), beginning January 1, 2000.

(i) For a total replacement, as defined in paragraph (g), authorized under section 144A.073 for a 96–bed nursing home in Carlton county, the replacement–costs–new per bed limit shall be $74,280 per licensed bed in multiple–bed rooms, $92,850 per licensed bed in semiprivate rooms with a fixed partition separating the resident's beds, and $111,420 per licensed bed in a single room. Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), does not apply. The resulting maximum allowable replacement–costs–new multiplied by 1.25 shall constitute the project's dollar threshold for purposes of application of the limit set forth in section 144A.071, subdivision 2. The commissioner of health may waive the requirements of section 144A.073, subdivision 3b, paragraph (b), clause (2), on the condition that the other requirements of that paragraph are met.

[For text of subds 18 to 25, see M.S.1998]

Subd. 26. **Changes to nursing facility reimbursement beginning July 1, 1997.** The nursing facility reimbursement changes in paragraphs (a) to (f) shall apply in the sequence specified in Minnesota Rules, parts 9549.0010 to 9549.0080, and this section, beginning July 1, 1997.

(a) For rate years beginning on or after July 1, 1997, the commissioner shall limit a nursing facility's allowable operating per diem for each case mix category for each rate year. The commissioner shall group nursing facilities into two groups, freestanding and nonfreestanding, within each geographic group, using their operating cost per diem for the case mix A classification. A nonfreestanding nursing facility is a nursing facility whose other operating cost per diem is subject to the hospital attached, short length of stay, or the rule 80 limits. All other nursing facilities shall be considered freestanding nursing facilities. The commissioner shall then array all nursing facilities in each grouping by their allowable case mix A operating cost per diem. In calculating a nursing facility's operating cost per diem for this purpose, the commissioner shall exclude the raw food cost per diem related to providing special diets that are based on religious beliefs, as determined in subdivision 2b, paragraph (h). For those nursing facilities in each grouping whose case mix A operating cost per diem:

(1) is at or below the median of the array, the commissioner shall limit the nursing facility's allowable operating cost per diem for each case mix category to the lesser of the prior reporting year's allowable operating cost per diem as specified in Laws 1996, chapter 451, article 3, section 11, paragraph (h), plus the inflation factor as established in paragraph (d), clause (2), increased by two percentage points, or the current reporting year's corresponding allowable operating cost per diem; or

(2) is above the median of the array, the commissioner shall limit the nursing facility's allowable operating cost per diem for each case mix category to the lesser of the prior reporting year's allowable operating cost per diem as specified in Laws 1996, chapter 451, article 3, section 11, paragraph (h), plus the inflation factor as established in paragraph (d), clause (2), increased by one percentage point, or the current reporting year's corresponding allowable operating cost per diem.

For purposes of paragraph (a), if a nursing facility reports on its cost report a reduction in cost due to a refund or credit for a rate year beginning on or after July 1, 1998, the commissioner shall increase that facility's spend–up limit for the rate year following the current rate year by the amount of the cost reduction divided by its resident days for the reporting year preceding the rate year in which the adjustment is to be made.

(b) For rate years beginning on or after July 1, 1997, the commissioner shall limit the allowable operating cost per diem for high cost nursing facilities. After application of the limits in paragraph (a) to each nursing facility's operating cost per diem, the commissioner shall group nursing facilities into two groups, freestanding or nonfreestanding, within each geographic group. A nonfreestanding nursing facility is a nursing facility whose other operating cost per diem are subject to hospital attached, short length of stay, or rule 80 limits. All other nursing facilities shall be considered freestanding nursing facilities. The commissioner shall then array all nursing facilities within each grouping by their allowable case mix A op-

erating cost per diem. In calculating a nursing facility's operating cost per diem for this purpose, the commissioner shall exclude the raw food cost per diem related to providing special diets that are based on religious beliefs, as determined in subdivision 2b, paragraph (h). For those nursing facilities in each grouping whose case mix A operating cost per diem exceeds 1.0 standard deviation above the median, the commissioner shall reduce their allowable operating cost per diem by three percent. For those nursing facilities in each grouping whose case mix A operating cost per diem exceeds 0.5 standard deviation above the median but is less than or equal to 1.0 standard deviation above the median, the commissioner shall reduce their allowable operating cost per diem by two percent. However, in no case shall a nursing facility's operating cost per diem be reduced below its grouping's limit established at 0.5 standard deviations above the median.

(c) For rate years beginning on or after July 1, 1997, the commissioner shall determine a nursing facility's efficiency incentive by first computing the allowable difference, which is the lesser of $4.50 or the amount by which the facility's other operating cost limit exceeds its nonadjusted other operating cost per diem for that rate year. The commissioner shall compute the efficiency incentive by:

(1) subtracting the allowable difference from $4.50 and dividing the result by $4.50;

(2) multiplying 0.20 by the ratio resulting from clause (1), and then;

(3) adding 0.50 to the result from clause (2); and

(4) multiplying the result from clause (3) times the allowable difference.

The nursing facility's efficiency incentive payment shall be the lesser of $2.25 or the product obtained in clause (4).

(d) For rate years beginning on or after July 1, 1997, the forecasted price index for a nursing facility's allowable operating cost per diem shall be determined under clauses (1) and (2) using the change in the Consumer Price Index–All Items (United States city average) (CPI–U) as forecasted by Data Resources, Inc. The commissioner shall use the indices as forecasted in the fourth quarter of the calendar year preceding the rate year, subject to subdivision 2l, paragraph (c).

(1) The CPI–U forecasted index for allowable operating cost per diem shall be based on the 21–month period from the midpoint of the nursing facility's reporting year to the midpoint of the rate year following the reporting year.

(2) For rate years beginning on or after July 1, 1997, the forecasted index for operating cost limits referred to in subdivision 21, paragraph (b), shall be based on the CPI–U for the 12–month period between the midpoints of the two reporting years preceding the rate year.

(e) After applying these provisions for the respective rate years, the commissioner shall index these allowable operating cost per diem by the inflation factor provided for in paragraph (d), clause (1), and add the nursing facility's efficiency incentive as computed in paragraph (c).

(f) For rate years beginning on or after July 1, 1997, the total operating cost payment rates for a nursing facility shall be the greater of the total operating cost payment rates determined under this section or the total operating cost payment rates in effect on June 30, 1997, subject to rate adjustments due to field audit or rate appeal resolution. This provision shall not apply to subsequent field audit adjustments of the nursing facility's operating cost rates for rate years beginning on or after July 1, 1997.

(g) For the rate years beginning on July 1, 1997, July 1, 1998, and July 1, 1999, a nursing facility licensed for 40 beds effective May 1, 1992, with a subsequent increase of 20 Medicare/Medicaid certified beds, effective January 26, 1993, in accordance with an increase in licensure is exempt from paragraphs (a) and (b).

(h) For a nursing facility whose construction project was authorized according to section 144A.073, subdivision 5, paragraph (g), the operating cost payment rates for the new location shall be determined based on Minnesota Rules, part 9549.0057. The relocation allowed under section 144A.073, subdivision 5, paragraph (g), and the rate determination allowed under this paragraph must meet the cost neutrality requirements of section 144A.073, subdivision 3c. Paragraphs (a) and (b) shall not apply until the second rate year after the settle–up cost report is filed. Notwithstanding subdivision 2b, paragraph (g), real estate taxes and special assessments payable by the new location, a 501(c)(3) nonprofit corporation, shall

be included in the payment rates determined under this subdivision for all subsequent rate years.

(i) For the rate year beginning July 1, 1997, the commissioner shall compute the payment rate for a nursing facility licensed for 94 beds on September 30, 1996, that applied in October 1993 for approval of a total replacement under the moratorium exception process in section 144A.073, and completed the approved replacement in June 1995, with other operating cost spend–up limit under paragraph (a), increased by $3.98, and after computing the facility's payment rate according to this section, the commissioner shall make a one–year positive rate adjustment of $3.19 for operating costs related to the newly constructed total replacement, without application of paragraphs (a) and (b). The facility's per diem, before the $3.19 adjustment, shall be used as the prior reporting year's allowable operating cost per diem for payment rate calculation for the rate year beginning July 1, 1998. A facility described in this paragraph is exempt from paragraph (b) for the rate years beginning July 1, 1997, and July 1, 1998.

(j) For the purpose of applying the limit stated in paragraph (a), a nursing facility in Kandiyohi county licensed for 86 beds that was granted hospital–attached status on December 1, 1994, shall have the prior year's allowable care–related per diem increased by $3.207 and the prior year's other operating cost per diem increased by $4.777 before adding the inflation in paragraph (d), clause (2), for the rate year beginning on July 1, 1997.

(k) For the purpose of applying the limit stated in paragraph (a), a 117 bed nursing facility located in Pine county shall have the prior year's allowable other operating cost per diem increased by $1.50 before adding the inflation in paragraph (d), clause (2), for the rate year beginning on July 1, 1997.

(l) For the purpose of applying the limit under paragraph (a), a nursing facility in Hibbing licensed for 192 beds shall have the prior year's allowable other operating cost per diem increased by $2.67 before adding the inflation in paragraph (d), clause (2), for the rate year beginning July 1, 1997.

[For text of subd 27, see M.S.1998]

Subd. 28. **Nursing facility rate increases beginning July 1, 1999, and July 1, 2000.** (a) For the rate years beginning July 1, 1999, and July 1, 2000, the commissioner shall make available to each nursing facility reimbursed under this section or section 256B.434 an adjustment to the total operating payment rate. For each facility, total operating costs shall be separated into costs that are compensation related and all other costs. Compensation–related costs include salaries, payroll taxes, and fringe benefits for all employees except management fees, the administrator, and central office staff.

(b) For the rate year beginning July 1, 1999, the commissioner shall make available a rate increase for compensation–related costs of 4.843 percent and a rate increase for all other operating costs of 3.446 percent.

(c) For the rate year beginning July 1, 2000, the commissioner shall make available a rate increase for compensation–related costs of 3.632 percent and a rate increase for all other operating costs of 2.585 percent.

(d) The payment rate adjustment for each nursing facility must be determined under clause (1) or (2):

(1) for each nursing facility that reports salaries for registered nurses, licensed practical nurses, aides, orderlies, and attendants separately, the commissioner shall determine the payment rate adjustment using the categories specified in paragraph (a) multiplied by the rate increases specified in paragraph (b) or (c), and then dividing the resulting amount by the nursing facility's actual resident days. In determining the amount of a payment rate adjustment for a nursing facility reimbursed under section 256B.434, the commissioner shall determine the proportions of the facility's rates that are compensation–related costs and all other operating costs based on the facility's most recent cost report; and

(2) for each nursing facility that does not report salaries for registered nurses, licensed practical nurses, aides, orderlies, and attendants separately, the payment rate adjustment shall be computed using the facility's total operating costs, separated into the categories spe-

cified in paragraph (a) in proportion to the weighted average of all facilities determined under clause (1), multiplied by the rate increases specified in paragraph (b) or (c), and then dividing the resulting amount by the nursing facility's actual resident days.

(e) A nursing facility may apply for the compensation–related payment rate adjustment calculated under this subdivision. The application must be made to the commissioner and contain a plan by which the nursing facility will distribute the compensation–related portion of the payment rate adjustment to employees of the nursing facility. For nursing facilities in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes the plan. The commissioner shall review the plan to ensure that the payment rate adjustment per diem is used as provided in paragraphs (a) to (c). To be eligible, a facility must submit its plan for the compensation distribution by December 31 each year. A facility may amend its plan for the second rate year by submitting a revised plan by December 31, 2000. If a facility's plan for compensation distribution is effective for its employees after July 1 of the year that the funds are available, the payment rate adjustment per diem shall be effective the same date as its plan.

(f) A copy of the approved distribution plan must be made available to all employees. This must be done by giving each employee a copy or by posting it in an area of the nursing facility to which all employees have access. If an employee does not receive the compensation adjustment described in their facility's approved plan and is unable to resolve the problem with the facility's management or through the employee's union representative, the employee may contact the commissioner at an address or phone number provided by the commissioner and included in the approved plan.

(g) If the reimbursement system under section 256B.435 is not implemented until July 1, 2001, the salary adjustment per diem authorized in subdivision 2i, paragraph (c), shall continue until June 30, 2001.

(h) For the rate year beginning July 1, 1999, the following nursing facilities shall be allowed a rate increase equal to 67 percent of the rate increase that would be allowed if subdivision 26, paragraph (a), was not applied:

(1) a nursing facility in Carver county licensed for 33 nursing home beds and four boarding care beds;

(2) a nursing facility in Faribault county licensed for 159 nursing home beds on September 30, 1998; and

(3) a nursing facility in Houston county licensed for 68 nursing home beds on September 30, 1998.

(i) For the rate year beginning July 1, 1999, the following nursing facilities shall be allowed a rate increase equal to 67 percent of the rate increase that would be allowed if subdivision 26, paragraphs (a) and (b), were not applied:

(1) a nursing facility in Chisago county licensed for 135 nursing home beds on September 30, 1998; and

(2) a nursing facility in Murray county licensed for 62 nursing home beds on September 30, 1998.

(j) For the rate year beginning July 1, 1999, a nursing facility in Hennepin county licensed for 134 beds on September 30, 1998, shall:

(1) have the prior year's allowable care–related per diem increased by $3.93 and the prior year's other operating cost per diem increased by $1.69 before adding the inflation in subdivision 26, paragraph (d), clause (2); and

(2) be allowed a rate increase equal to 67 percent of the rate increase that would be allowed if subdivision 26, paragraphs (a) and (b), were not applied.

History: *1999 c 245 art 3 s 17–20*

256B.434 CONTRACTUAL ALTERNATIVE PAYMENT DEMONSTRATION PROJECT FOR NURSING HOMES.

[For text of subds 1 and 2, see M.S.1998]

Subd. 3. **Duration and termination of contracts.** (a) Subject to available resources, the commissioner may begin to execute contracts with nursing facilities November 1, 1995.

(b) All contracts entered into under this section are for a term of one year. Either party may terminate a contract at any time without cause by providing 90 calendar days advance written notice to the other party. The decision to terminate a contract is not appealable. Notwithstanding section 16C.05, subdivision 2, paragraph (a), clause (5), the contract shall be renegotiated for additional one–year terms, unless either party provides written notice of termination. The provisions of the contract shall be renegotiated annually by the parties prior to the expiration date of the contract. The parties may voluntarily renegotiate the terms of the contract at any time by mutual agreement.

(c) If a nursing facility fails to comply with the terms of a contract, the commissioner shall provide reasonable notice regarding the breach of contract and a reasonable opportunity for the facility to come into compliance. If the facility fails to come into compliance or to remain in compliance, the commissioner may terminate the contract. If a contract is terminated, the contract payment remains in effect for the remainder of the rate year in which the contract was terminated, but in all other respects the provisions of this section do not apply to that facility effective the date the contract is terminated. The contract shall contain a provision governing the transition back to the cost–based reimbursement system established under section 256B.431, subdivision 25, and Minnesota Rules, parts 9549.0010 to 9549.0080. A contract entered into under this section may be amended by mutual agreement of the parties.

Subd. 4. **Alternate rates for nursing facilities.** (a) For nursing facilities which have their payment rates determined under this section rather than section 256B.431, subdivision 25, the commissioner shall establish a rate under this subdivision. The nursing facility must enter into a written contract with the commissioner.

(b) A nursing facility's case mix payment rate for the first rate year of a facility's contract under this section is the payment rate the facility would have received under section 256B.431, subdivision 25.

(c) A nursing facility's case mix payment rates for the second and subsequent years of a facility's contract under this section are the previous rate year's contract payment rates plus an inflation adjustment. The index for the inflation adjustment must be based on the change in the Consumer Price Index–All Items (United States City average) (CPI–U) forecasted by Data Resources, Inc., as forecasted in the fourth quarter of the calendar year preceding the rate year. The inflation adjustment must be based on the 12–month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined. For the rate years beginning on July 1, 1999, and July 1, 2000, this paragraph shall apply only to the property–related payment rate. In determining the amount of the property–related payment rate adjustment under this paragraph, the commissioner shall determine the proportion of the facility's rates that are property–related based on the facility's most recent cost report.

(d) The commissioner shall develop additional incentive–based payments of up to five percent above the standard contract rate for achieving outcomes specified in each contract. The specified facility–specific outcomes must be measurable and approved by the commissioner. The commissioner may establish, for each contract, various levels of achievement within an outcome. After the outcomes have been specified the commissioner shall assign various levels of payment associated with achieving the outcome. Any incentive–based payment cancels if there is a termination of the contract. In establishing the specified outcomes and related criteria the commissioner shall consider the following state policy objectives:

(1) improved cost effectiveness and quality of life as measured by improved clinical outcomes;

(2) successful diversion or discharge to community alternatives;

(3) decreased acute care costs;

(4) improved consumer satisfaction;

(5) the achievement of quality; or

(6) any additional outcomes proposed by a nursing facility that the commissioner finds desirable.

Subd. 4a. **Facility rate increases.** For the rate year beginning July 1, 1999, the nursing facilities described in clauses (1) to (5) shall receive the rate increases indicated. The increases provided under this subdivision shall be included in the facility's total payment rates for the purpose of determining future rates under this section or any other section:

(1) a nursing facility in Becker county licensed for 102 nursing home beds on September 30, 1998, shall receive an increase of $1.30 in its case mix class A payment rate; an increase of $1.33 in its case mix class B payment rate; an increase of $1.36 in its case mix class C payment rate; an increase of $1.39 in its case mix class D payment rate; an increase of $1.42 in its case mix class E payment rate; an increase of $1.42 in its case mix class F payment rate; an increase of $1.45 in its case mix class G payment rate; an increase of $1.49 in its case mix class H payment rate; an increase of $1.51 in its case mix class I payment rate; an increase of $1.54 in its case mix class J payment rate; and an increase of $1.59 in its case mix class K payment rate;

(2) a nursing facility in Chisago county licensed for 101 nursing home beds on September 30, 1998, shall receive an increase of $3.67 in each case mix payment rate;

(3) a nursing facility in Canby, licensed for 75 beds shall have its property–related per diem rate increased by $1.21. This increase shall be recognized in the facility's contract payment rate under this section;

(4) a nursing facility in Golden Valley with all its beds licensed to provide residential rehabilitative services to young adults under Minnesota Rules, parts 9570.2000 to 9570.3400, shall have the payment rate computed according to this section increased by $14.83; and

(5) a county–owned 130–bed nursing facility in Park Rapids shall have its per diem contract payment rate increased by $1.02 for costs related to compliance with comparable worth requirements.

[For text of subds 5 to 12, see M.S.1998]

Subd. 13. **Payment system reform advisory committee.** The commissioner, in consultation with an advisory committee, shall study options for reforming the regulatory and reimbursement system for nursing facilities to reduce the level of regulation, reporting, and procedural requirements, and to provide greater flexibility and incentives to stimulate competition and innovation. The advisory committee shall include, at a minimum, representatives from the long–term care provider community, the department of health, and consumers of long–term care services. Among other things, the commissioner shall consider the feasibility and desirability of changing from a certification requirement to an accreditation requirement for participation in the medical assistance program, options to encourage early discharge of short–term residents through the provision of intensive therapy, and further modifications needed in rate equalization. The commissioner shall also include detailed recommendations for a permanent managed care payment system to replace the contractual alternative payment demonstration project authorized under this section. The commissioner shall submit a report with findings and recommendations to the legislature by January 15, 1997.

[For text of subds 14 to 16, see M.S.1998]

Subd. 17. [Repealed, 1999 c 245 art 3 s 51]

History: *1999 c 245 art 3 s 21–24*

256B.435 NURSING FACILITY REIMBURSEMENT SYSTEM EFFECTIVE JULY 1, 2001.

Subdivision 1. **In general.** Effective July 1, 2001, the commissioner shall implement a performance–based contracting system to replace the current method of setting operating

cost payment rates under sections 256B.431 and 256B.434 and Minnesota Rules, parts 9549.0010 to 9549.0080. Operating cost payment rates for newly established facilities under Minnesota Rules, part 9549.0057, shall be established using section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0070. A nursing facility in operation on May 1, 1998, with payment rates not established under section 256B.431 or 256B.434 on that date, is ineligible for this performance–based contracting system. In determining prospective payment rates of nursing facility services, the commissioner shall distinguish between operating costs and property–related costs. The commissioner of finance shall include an annual inflationary adjustment in operating costs for nursing facilities using the inflation factor specified in subdivision 3 and funding for incentive–based payments as a budget change request in each biennial detailed expenditure budget submitted to the legislature under section 16A.11. Property related payment rates, including real estate taxes and special assessments, shall be determined under section 256B.431 or 256B.434 or under a new property–related reimbursement system, if one is implemented by the commissioner under subdivision 3. The commissioner shall present additional recommendations for performance–based contracting for nursing facilities to the legislature by February 15, 2000, in the following specific areas:

(1) development of an interim default payment mechanism for nursing facilities that do not respond to the state's request for proposal but wish to continue participation in the medical assistance program, and nursing facilities the state does not select in the request for proposal process, and nursing facilities whose contract has been canceled;

(2) development of criteria for facilities to earn performance–based incentive payments based on relevant outcomes negotiated by nursing facilities and the commissioner and that recognize both continuous quality efforts and quality improvement;

(3) development of criteria and a process under which nursing facilities can request rate adjustments for low base rates, geographic disparities, or other reasons;

(4) development of a dispute resolution mechanism for nursing facilities that are denied a contract, denied incentive payments, or denied a rate adjustment;

(5) development of a property payment system to address the capital needs of nursing facilities that will be funded with additional appropriations;

(6) establishment of a transitional plan to move from dual assessment instruments to the federally mandated resident assessment system, whereby the financial impact for each facility would be budget neutral;

(7) identification of net cost implications for facilities and to the department of preparing for and implementing performance–based contracting or any proposed alternative system;

(8) identification of facility financial and statistical reporting requirements; and

(9) identification of exemptions from current regulations and statutes applicable under performance–based contracting.

Subd. 1a. **Requests for proposals.** (a) For nursing facilities with rates established under section 256B.434 on January 1, 2001, the commissioner shall renegotiate contracts without requiring a response to a request for proposal, notwithstanding the solicitation process described in chapter 16C.

(b) Prior to July 1, 2001, the commissioner shall publish in the State Register a request for proposals to provide nursing facility services according to this section. The commissioner will consider proposals from all nursing facilities that have payment rates established under section 256B.431. The commissioner must respond to all proposals in a timely manner.

(c) In issuing a request for proposals, the commissioner may develop reasonable requirements which, in the judgment of the commissioner, are necessary to protect residents or ensure that the performance–based contracting system furthers the interests of the state of Minnesota. The request for proposals may include, but need not be limited to:

(1) a requirement that a nursing facility make reasonable efforts to maximize Medicare payments on behalf of eligible residents;

(2) requirements designed to prevent inappropriate or illegal discrimination against residents enrolled in the medical assistance program as compared to private paying residents;

(3) requirements designed to ensure that admissions to a nursing facility are appropriate and that reasonable efforts are made to place residents in home and community–based settings when appropriate;

(4) a requirement to agree to participate in the development of data collection systems and outcome–based standards. Among other requirements specified by the commissioner, each facility entering into a contract may be required to pay an annual fee not to exceed $1,000. The commissioner must use revenue generated from the fees to contract with a qualified consultant or contractor to develop data collection systems and outcome–based contracting standards;

(5) a requirement that Medicare–certified contractors agree to maintain Medicare cost reports and to submit them to the commissioner upon request, or at times specified by the commissioner; and that contractors that are not Medicare–certified agree to maintain a uniform cost report in a format established by the commissioner and to submit the report to the commissioner upon request, or at times specified by the commissioner;

(6) a requirement that demonstrates willingness and ability to develop and maintain data collection and retrieval systems to measure outcomes; and

(7) a requirement to provide all information and assurances required by the terms and conditions of the federal waiver or federal approval.

(d) In addition to the information and assurances contained in the submitted proposals, the commissioner may consider the following criteria in developing the terms of the contract:

(1) the facility's history of compliance with federal and state laws and rules. A facility deemed to be in substantial compliance with federal and state laws and rules is eligible to respond to a request for proposals. A facility's compliance history shall not be the sole determining factor in situations where the facility has been sold and the new owners have submitted a proposal;

(2) whether the facility has a record of excessive licensure fines or sanctions or fraudulent cost reports;

(3) the facility's financial history and solvency; and

(4) other factors identified by the commissioner deemed relevant to developing the terms of the contract, including a determination that a contract with a particular facility is not in the best interests of the residents of the facility or the state of Minnesota.

(e) Notwithstanding the requirements of the solicitation process described in chapter 16C, the commissioner may contract with nursing facilities established according to section 144A.073 without issuing a request for proposals.

(f) Notwithstanding subdivision 1, after July 1, 2001, the commissioner may contract with additional nursing facilities, according to requests for proposals.

Subd. 2. **Contract provisions.** (a) The performance–based contract with each nursing facility must include provisions that:

(1) apply the resident case mix assessment provisions of Minnesota Rules, parts 9549.0051, 9549.0058, and 9549.0059, or another assessment system, with the goal of moving to a single assessment system;

(2) monitor resident outcomes through various methods, such as quality indicators based on the minimum data set and other utilization and performance measures;

(3) require the establishment and use of a continuous quality improvement process that integrates information from quality indicators and regular resident and family satisfaction interviews;

(4) require annual reporting of facility statistical information, including resident days by case mix category, productive nursing hours, wages and benefits, and raw food costs for use by the commissioner in the development of facility profiles that include trends in payment and service utilization;

(5) require from each nursing facility an annual certified audited financial statement consisting of a balance sheet, income and expense statements, and an opinion from either a licensed or certified public accountant, if a certified audit was prepared, or unaudited financial statements if no certified audit was prepared;

(6) specify the method for resolving disputes; and

(7) establish additional requirements for nursing facilities not meeting the standards set forth in the performance–based contract.

(b) The commissioner may develop additional incentive–based payments for achieving specified outcomes specified in each contract. The specified facility–specific outcomes must be measurable and approved by the commissioner.

(c) The commissioner may also contract with nursing facilities in other ways through requests for proposals, including contracts on a risk or nonrisk basis, with nursing facilities or consortia of nursing facilities, to provide comprehensive long–term care coverage on a premium or capitated basis.

(d) The commissioner may negotiate different contract terms for different nursing facilities.

Subd. 2a. **Duration and termination of contracts.** (a) All contracts entered into under this section are for a term of one year. Either party may terminate this contract at any time without cause by providing 90 calendar days' advance written notice to the other party. Notwithstanding section 16C.05, subdivisions 2, paragraph (a), and 5, if neither party provides written notice of termination, the contract shall be renegotiated for additional one–year terms or the terms of the existing contract will be extended for one year. The provisions of the contract shall be renegotiated annually by the parties prior to the expiration date of the contract. The parties may voluntarily renegotiate the terms of the contract at any time by mutual agreement.

(b) If a nursing facility fails to comply with the terms of a contract, the commissioner shall provide reasonable notice regarding the breach of contract and a reasonable opportunity for the facility to come into compliance. If the facility fails to come into compliance or to remain in compliance, the commissioner may terminate the contract. If a contract is terminated, provisions of section 256B.48, subdivision 1a, shall apply.

Subd. 3. **Payment rate provisions.** (a) For rate years beginning on or after July 1, 2001, within the limits of appropriations specifically for this purpose, the commissioner shall determine operating cost payment rates for each licensed and certified nursing facility by indexing its operating cost payment rates in effect on June 30, 2001, for inflation. For rate years beginning on or after July 1, 2001, the inflation factor must be based on the change in the Employment Cost Index for Private Industry Workers – Total Compensation as forecasted by the commissioner of finance's national economic consultant, in the fourth quarter preceding the rate year. The forecasted index for operating cost payment rates shall be based on the 12–month period from the midpoint of the nursing facility's prior rate year to the midpoint of the rate year for which the operating payment rate is being determined. The operating cost payment rate to be inflated shall be the total payment rate in effect on June 30, 2001, minus the portion determined to be the property–related payment rate, minus the per diem amount of the preadmission screening cost included in the nursing facility's last payment rate established under section 256B.431.

(b) A per diem amount for preadmission screening will be added onto the contract payment rates according to the method of distribution of county allocation described in section 256B.0911, subdivision 6, paragraph (a).

(c) For rate years beginning on or after July 1, 2001, the commissioner may implement a new method of payment for property–related costs that addresses the capital needs of facilities. The new property payment system or systems, if implemented, shall replace the current methods of setting property payment rates under sections 256B.431 and 256B.434.

Subd. 4. **Contract payment rates; appeals.** If an appeal is pending concerning the cost–based payment rates that are the basis for the calculation of the payment rate under this section, the commissioner and the nursing facility may agree on an interim contract rate to be used until the appeal is resolved. When the appeal is resolved, the contract rate must be adjusted retroactively according to the appeal decision.

Subd. 5. **Consumer protection.** In addition to complying with all applicable laws regarding consumer protection, as a condition of entering into a contract under this section, a nursing facility must agree to:

(1) establish resident grievance procedures;

(2) establish expedited grievance procedures to resolve complaints made by short–stay residents; and

(3) make available to residents and families a copy of the performance–based contract and outcomes to be achieved.

Subd. 6. **Contracts are voluntary.** Participation of nursing facilities in the medical assistance program is voluntary. The terms and procedures governing the performance–based contract are determined under this section and through negotiations between the commissioner and nursing facilities.

Subd. 7. **Federal requirements.** The commissioner shall implement the performance–based contracting system subject to any required federal waivers or approval and in a manner that is consistent with federal requirements. If a provision of this section is inconsistent with a federal requirement, the federal requirement supersedes the inconsistent provision. The commissioner shall seek federal approval and request waivers as necessary to implement this section.

History: *1999 c 245 art 3 s 25*

256B.47 NONALLOWABLE COSTS; NOTICE OF INCREASES TO PRIVATE PAYING RESIDENTS; ALLOCATION OF COSTS.

Subdivision 1. **Nonallowable costs.** The following costs shall not be recognized as allowable: (1) political contributions; (2) salaries or expenses of a lobbyist, as defined in section 10A.01, subdivision 21, for lobbying activities; (3) advertising designed to encourage potential residents to select a particular nursing facility; (4) assessments levied by the commissioner of health for uncorrected violations; (5) legal and related expenses for unsuccessful challenges to decisions by governmental agencies; (6) memberships in sports, health or similar social clubs or organizations; (7) costs incurred for activities directly related to influencing employees with respect to unionization; and (8) direct and indirect costs of providing services which are billed separately from the nursing facility's payment rate or pursuant to Minnesota Rules, parts 9500.0750 to 9500.1080. The commissioner shall by rule exclude the costs of any other items not directly related to the provision of resident care.

[For text of subds 2 to 4, see M.S.1998]

History: *1999 c 220 s 50*

256B.48 CONDITIONS FOR PARTICIPATION.

Subdivision 1. **Prohibited practices.** A nursing facility 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 facility 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 facility 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 facility in order to comply with licensure or certification standards and that if not provided would result in a deficiency or violation by the nursing facility. 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 facility 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 facility 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 facility 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)(1) Charging, soliciting, accepting, or receiving from an applicant for admission to the facility, or from anyone acting in behalf of the applicant, as a condition of admission, expediting the admission, or as a requirement for the individual's continued stay, any fee, deposit, gift, money, donation, or other consideration not otherwise required as payment under the state plan;

(2) requiring an individual, or anyone acting in behalf of the individual, to loan any money to the nursing facility;

(3) requiring an individual, or anyone acting in behalf of the individual, to promise to leave all or part of the individual's estate to the facility; or

(4) requiring a third–party guarantee of payment to the facility as a condition of admission, expedited admission, or continued stay in the facility.

Nothing in this paragraph would prohibit discharge for nonpayment of services in accordance with state and federal regulations.

(c) Requiring any resident of the nursing facility to utilize a vendor of health care services chosen by the nursing facility. A nursing facility may require a resident to use pharmacies that utilize unit dose packing systems approved by the Minnesota board of pharmacy, and may require a resident to use pharmacies that are able to meet the federal regulations for safe and timely administration of medications such as systems with specific number of doses, prompt delivery of medications, or access to medications on a 24–hour basis. Notwithstanding the provisions of this paragraph, nursing facilities shall not restrict a resident's choice of pharmacy because the pharmacy utilizes a specific system of unit dose drug packing.

(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 facility, or the applicant's guardian or conservator, that the applicant is neither eligible for nor will seek public assistance for payment of nursing facility 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 facility of financial information of any applicant pursuant to a preadmission screening program established by law shall not raise an inference that the nursing facility 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 facility except as payment for renting or leasing space or equipment or purchasing support services from the nursing facility as limited by section 256B.433. All agreements must be disclosed to the commissioner upon request of the commissioner. Nursing facilities 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.

For a period not to exceed 180 days, the commissioner may continue to make medical assistance payments to a nursing facility 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 facility to correct the violation. The nursing facility 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 facility 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 facility 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 facility is not eligible for reimbursement for a resident who is eligible for medical assistance, the commissioner may authorize the nursing facility to receive reimbursement on a temporary basis until the resident can be relocated to a participating nursing facility.

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.

Subd. 1a. **Termination.** If a nursing facility terminates its participation in the medical assistance program, whether voluntarily or involuntarily, the commissioner may authorize the nursing facility to receive continued medical assistance reimbursement until medical assistance residents can be relocated to nursing facilities participating in the medical assistance program.

Subd. 1b. **Exception.** Notwithstanding any agreement between a nursing facility and the department of human services or the provisions of this section or section 256B.411, other than subdivision 1a, the commissioner may authorize continued medical assistance payments to a nursing facility which ceased intake of medical assistance recipients prior to July 1, 1983, and which charges private paying residents rates that exceed those permitted by subdivision 1, paragraph (a), for (i) residents who resided in the nursing facility before July 1, 1983, or (ii) residents for whom the commissioner or any predecessors of the commissioner granted a permanent individual waiver prior to October 1, 1983. Nursing facilities seeking continued medical assistance payments under this subdivision shall make the reports required under subdivision 2, except that on or after December 31, 1985, the financial statements required need not be audited by or contain the opinion of a certified public accountant or licensed public accountant, but need only be reviewed by a certified public accountant or licensed public accountant. In the event that the state is determined by the federal government to be no longer eligible for the federal share of medical assistance payments made to a nursing facility under this subdivision, the commissioner may cease medical assistance payments, under this subdivision, to that nursing facility.

[For text of subds 1c to 5, see M.S.1998]

Subd. 6. **Medicare certification.** (a) **Definition.** For purposes of this subdivision, "nursing facility" means a nursing facility that is certified as a skilled nursing facility or, after September 30, 1990, a nursing facility licensed under chapter 144A that is certified as a nursing facility.

(b) **Medicare participation required.** All nursing facilities shall participate in Medicare part A and part B unless, after submitting an application, Medicare certification is denied by the federal health care financing administration. Medicare review shall be conducted at the time of the annual medical assistance review. Charges for Medicare–covered services provided to residents who are simultaneously eligible for medical assistance and Medicare must be billed to Medicare part A or part B before billing medical assistance. Medical assistance may be billed only for charges not reimbursed by Medicare.

(c) **After September 30, 1990.** After September 30, 1990, a nursing facility satisfies the requirements of paragraph (b) if at least 50 percent of the facility's beds certified as nursing facility beds under the medical assistance program are Medicare certified.

(d) **Conflict with Medicare distinct part requirements.** At the request of a facility, the commissioner of human services may reduce the 50 percent Medicare participation requirement in paragraph (c) to no less than 20 percent if the commissioner of health determines that, due to the facility's physical plant configuration, the facility cannot satisfy Medicare distinct part requirements at the 50 percent certification level. To receive a reduction in the participation requirement, a facility must demonstrate that the reduction will not adversely affect access of Medicare–eligible residents to Medicare–certified beds.

(e) **Institutions for mental disease.** The commissioner may grant exceptions to the requirements of paragraph (b) for nursing facilities that are designated as institutions for mental disease.

(f) **Notice of rights.** The commissioner shall inform recipients of their rights under this subdivision and section 144.651, subdivision 29.

[For text of subds 7 to 9, see M.S.1998]

History: *1999 c 245 art 3 s 26–29; 1999 c 245 art 4 s 67*

256B.49 CHRONICALLY ILL CHILDREN AND DISABLED PERSONS; HOME AND COMMUNITY–BASED WAIVER STUDY AND APPLICATION.

[For text of subds 1 to 9, see M.S.1998]

Subd. 10. **Private duty nursing services provided by a spouse.** The commissioner shall seek to amend the community alternative care home and community–based waivered services program to include payment for spouses providing private duty nursing care to a recipient who can direct his or her own care. For purposes of this subdivision, a recipient can direct his or her own care if the recipient can communicate:

(1) orientation to person, place, and time;

(2) an understanding of the recipient's plan of care, including medications and medication schedule;

(3) needs; and

(4) an understanding of safety issues, including how to access emergency assistance.

Private duty nursing may be provided by a spouse who is a licensed nurse employed by a Medicare certified home health agency, in cases where there is a lack of a sufficient number of qualified providers or private duty nurses and to prevent the hospitalization of the recipient. Private duty nursing services provided by a spouse cannot be used in lieu of nursing services covered and available under liable third–party payers including Medicare and medical assistance not paid by the waiver. The private duty nursing provided by a spouse must be included in the plan of care and must be scheduled by the home health agency, and may be covered for up to 24 hours per week. In no case shall the authorization of these services provided by the spouse exceed 50 percent of the total approved nursing hours or eight hours per day, whichever is less. Nothing in this subdivision precludes the spouse's obligation of assuming the nonreimbursed family responsibilities of emergency backup caregiver and primary caregiver. The waiver interdisciplinary team shall recommend to the commissioner whether the provision of private duty nursing care by a spouse is appropriate. In no case shall a spouse be paid to provide private duty nursing care if the spouse fails to pass a criminal background check according to section 245A.04, or if it has been determined by the home health agency or the waiver case manager that the private duty nursing care provided by the spouse is unsafe. This subdivision is effective upon the date of federal approval.

History: *1999 c 156 s 1*

256B.50 APPEALS.

[For text of subds 1 to 1c, see M.S.1998]

Subd. 1e. **Attorney's fees and costs.** (a) Notwithstanding section 15.472, paragraph (a), for an issue appealed under subdivision 1, the prevailing party in a contested case pro-

ceeding or, if appealed, in subsequent judicial review, must be awarded reasonable attorney's fees and costs incurred in litigating the appeal, if the prevailing party shows that the position of the opposing party was not substantially justified. The procedures for awarding fees and costs set forth in section 15.474 must be followed in determining the prevailing party's fees and costs except as otherwise provided in this subdivision. For purposes of this subdivision, "costs" means subpoena fees and mileage, transcript costs, court reporter fees, witness fees, postage and delivery costs, photocopying and printing costs, amounts charged the commissioner by the office of administrative hearings, and direct administrative costs of the department; and "substantially justified" means that a position had a reasonable basis in law and fact, based on the totality of the circumstances prior to and during the contested case proceeding and subsequent review.

(b) When an award is made to the department under this subdivision, attorney fees must be calculated at the cost to the department. When an award is made to a provider under this subdivision, attorney fees must be calculated at the rate charged to the provider except that attorney fees awarded must be the lesser of the attorney's normal hourly fee or $100 per hour.

(c) In contested case proceedings involving more than one issue, the administrative law judge shall determine what portion of each party's attorney fees and costs is related to the issue or issues on which it prevailed and for which it is entitled to an award. In making that determination, the administrative law judge shall consider the amount of time spent on each issue, the precedential value of the issue, the complexity of the issue, and other factors deemed appropriate by the administrative law judge.

(d) When the department prevails on an issue involving more than one provider, the administrative law judge shall allocate the total amount of any award for attorney fees and costs among the providers. In determining the allocation, the administrative law judge shall consider each provider's monetary interest in the issue and other factors deemed appropriate by the administrative law judge.

(e) Attorney fees and costs awarded to the department for proceedings under this subdivision must not be reported or treated as allowable costs on the provider's cost report.

(f) Fees and costs awarded to a provider for proceedings under this subdivision must be reimbursed to them within 120 days of the final decision on the award of attorney fees and costs.

(g) If the provider fails to pay the awarded attorney fees and costs within 120 days of the final decision on the award of attorney fees and costs, the department may collect the amount due through any method available to it for the collection of medical assistance overpayments to providers. Interest charges must be assessed on balances outstanding after 120 days of the final decision on the award of attorney fees and costs. The annual interest rate charged must be the rate charged by the commissioner of revenue for late payment of taxes that is in effect on the 121st day after the final decision on the award of attorney fees and costs.

(h) Amounts collected by the commissioner pursuant to this subdivision must be deemed to be recoveries pursuant to section 256.01, subdivision 2, clause (15).

(i) This subdivision applies to all contested case proceedings set on for hearing by the commissioner on or after April 29, 1988, regardless of the date the appeal was filed.

[For text of subds 1f and 3, see M.S.1998]

History: *1999 c 245 art 3 s 30*

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

[For text of subds 1 to 8, see M.S.1998]

Subd. 8a. **Payment for persons with special needs for crisis intervention services.** Community–based crisis services authorized by the commissioner or the commissioner's designee for a resident of an intermediate care facility for persons with mental retardation (ICF/MR) reimbursed under this section shall be paid by medical assistance in accordance with the paragraphs (a) to (g).

(a) "Crisis services" means the specialized services listed in clauses (1) to (3) provided to prevent the recipient from requiring placement in a more restrictive institutional setting such as an inpatient hospital or regional treatment center and to maintain the recipient in the present community setting.

(1) The crisis services provider shall assess the recipient's behavior and environment to identify factors contributing to the crisis.

(2) The crisis services provider shall develop a recipient–specific intervention plan in coordination with the service planning team and provide recommendations for revisions to the individual service plan if necessary to prevent or minimize the likelihood of future crisis situations. The intervention plan shall include a transition plan to aid the recipient in returning to the community–based ICF/MR if the recipient is receiving residential crisis services.

(3) The crisis services provider shall consult with and provide training and ongoing technical assistance to the recipient's service providers to aid in the implementation of the intervention plan and revisions to the individual service plan.

(b) "Residential crisis services" means crisis services that are provided to a recipient admitted to an alternative, state–licensed site approved by the commissioner, because the ICF/MR receiving reimbursement under this section is not able, as determined by the commissioner, to provide the intervention and protection of the recipient and others living with the recipient that is necessary to prevent the recipient from requiring placement in a more restrictive institutional setting.

(c) Residential crisis services providers must maintain a license from the commissioner for the residence when providing crisis services for short–term crisis intervention, and must not be located in a private residence.

(d) Payment rates shall be established consistent with county negotiated crisis intervention services.

(e) Payment for residential crisis services is limited to 21 days, unless an additional period is authorized by the commissioner or part of an approved regional plan.

(f) Payment for crisis services shall be made only for services provided while the ICF/MR receiving reimbursement under this section:

(1) has a shared services agreement with the crisis services provider in effect under section 246.57; and

(2) has executed a cooperative agreement with the crisis services provider to implement the intervention plan and revisions to the individual service plan as necessary to prevent or minimize the likelihood of future crisis situations, to maintain the recipient in the present community setting, and to prevent the recipient from requiring a more restrictive institutional setting.

(g) Payment to the ICF/MR receiving reimbursement under this section shall be made for up to 18 therapeutic leave days during which the recipient is receiving residential crisis services, if the ICF/MR is otherwise eligible to receive payment for a therapeutic leave day under Minnesota Rules, part 9505.0415. Payment under this paragraph shall be terminated if the commissioner determines that the ICF/MR is not meeting the terms of the shared service agreement under paragraph (f) or that the recipient will not return to the ICF/MR.

[For text of subds 10 to 12, see M.S.1998]

History: *1999 c 245 art 4 s 69*

NOTE: Subdivision 3g is repealed by Laws 1999, chapter 245, article 3, section 51, effective October 1, 2000.

256B.5011 ICF/MR REIMBURSEMENT SYSTEM EFFECTIVE OCTOBER 1, 2000.

Subdivision 1. **In general.** Effective October 1, 2000, the commissioner shall implement a contracting system to replace the current method of setting total cost payment rates under section 256B.501 and Minnesota Rules, parts 9553.0010 to 9553.0080. In determining prospective payment rates of intermediate care facilities for persons with mental retardation or related conditions, the commissioner shall index each facility's operating payment rate by an inflation factor as described in section 256B.5012. The commissioner of finance shall in-

clude annual inflation adjustments in operating costs for intermediate care facilities for persons with mental retardation and related conditions as a budget change request in each biennial detailed expenditure budget submitted to the legislature under section 16A.11.

Subd. 2. **Contract provisions.** (a) The service contract with each intermediate care facility must include provisions for:

(1) modifying payments when significant changes occur in the needs of the consumers;

(2) the establishment and use of continuous quality improvement processes using the results attained through service quality monitoring;

(3) appropriate and necessary statistical information required by the commissioner;

(4) annual aggregate facility financial information; and

(5) additional requirements for intermediate care facilities not meeting the standards set forth in the service contract.

(b) The commissioner shall recommend to the legislature by January 15, 2000, whether the contract should include service quality monitoring that may utilize performance indicators that measure consumer and program outcomes. Performance measurement shall not increase or duplicate regulatory requirements.

Subd. 3. [Repealed, 1999 c 245 art 3 s 51]

History: *1999 c 245 art 3 s 31,32*

256B.5012 ICF/MR PAYMENT SYSTEM IMPLEMENTATION.

Subdivision 1. **Total payment rate.** The total payment rate effective October 1, 2000, for existing ICF/MR facilities is the total of the operating payment rate and the property payment rate plus inflation factors as defined in this section. The initial rate year shall run from October 1, 2000, through December 31, 2001. Subsequent rate years shall run from January 1 through December 31 beginning in the year 2002.

Subd. 2. **Operating payment rate.** (a) The operating payment rate equals the facility's total payment rate in effect on September 30, 2000, minus the property rate. The operating payment rate includes the special operating rate and the efficiency incentive in effect as of September 30, 2000. Within the limits of appropriations specifically for this purpose, the operating payment shall be increased for each rate year by the annual percentage change in the Employment Cost Index for Private Industry Workers – Total Compensation, as forecasted by the commissioner of finance's economic consultant, in the second quarter of the calendar year preceding the start of each rate year. In the case of the initial rate year beginning October 1, 2000, and continuing through December 31, 2001, the percentage change shall be based on the percentage change in the Employment Cost Index for Private Industry Workers – Total Compensation for the 15–month period beginning October 1, 2000, as forecast by Data Resources, Inc., in the first quarter of 2000.

(b) Effective October 1, 2000, the operating payment rate shall be adjusted to reflect an occupancy rate equal to 100 percent of the facility's capacity days as of September 30, 2000.

Subd. 3. **Property payment rate.** (a) The property payment rate effective October 1, 2000, is based on the facility's modified property payment rate in effect on September 30, 2000. The modified property payment rate is the actual property payment rate exclusive of the effect of gains or losses on disposal of capital assets or adjustments for excess depreciation claims. Effective October 1, 2000, a facility minimum property rate of $8.13 shall be applied to all existing ICF/MR facilities. Facilities with a modified property payment rate effective September 30, 2000, which is below the minimum property rate shall receive an increase effective October 1, 2000, equal to the difference between the minimum property payment rate and the modified property payment rate in effect as of September 30, 2000. Facilities with a modified property payment rate at or above the minimum property payment rate effective September 30, 2000, shall receive the modified property payment rate effective October 1, 2000.

(b) Within the limits of appropriations specifically for this purpose, facility property payment rates shall be increased annually for inflation, effective January 1, 2002. The increase shall be based on each facility's property payment rate in effect on September 30, 2000. Modified property payment rates effective September 30, 2000, shall be arrayed from

highest to lowest before applying the minimum property payment rate in paragraph (a). For modified property payment rates at the 90th percentile or above, the annual inflation increase shall be zero. For modified property payment rates below the 90th percentile but equal to or above the 75th percentile, the annual inflation increase shall be one percent. For modified property payment rates below the 75th percentile, the annual inflation increase shall be two percent.

History: *1999 c 245 art 3 s 33*

256B.5013 PAYMENT RATE ADJUSTMENTS.

Subdivision 1. **Variable rate adjustments.** When there is a documented increase in the resource needs of a current ICF/MR recipient or recipients, or a person is admitted to a facility who requires additional resources, the county of financial responsibility may approve an enhanced rate for one or more persons in the facility. Resource needs directly attributable to an individual that may be considered under the variable rate adjustment include increased direct staff hours and other specialized services, equipment, and human resources. The guidelines in paragraphs (a) to (d) apply for the payment rate adjustments under this section.

(a) All persons must be screened according to section 256B.092, subdivisions 7 and 8, prior to implementation of the new payment system and annually thereafter. Screening data shall be analyzed to develop broad profiles of the functional characteristics of recipients. Three components shall be used to distinguish recipients based on the following broad profiles:

(1) functional ability to care for and maintain one's own basic needs;

(2) the intensity of any aggressive or destructive behavior; and

(3) any history of obstructive behavior in combination with a diagnosis of psychosis or neurosis.

The profile groups shall be used to link resource needs to funding. The resource profile shall determine the level of funding that may be authorized by the county. The county of financial responsibility may approve a rate adjustment for an individual. The commissioner shall recommend to the legislature by January 15, 2000, a methodology using the profile groups to determine variable rates. The variable rate must be applied to expenses related to increased direct staff hours and other specialized services, equipment, and human resources. This variable rate component plus the facility's current operating payment rate equals the individual's total operating payment rate.

(b) A recipient must be screened by the county of financial responsibility using the developmental disabilities screening document completed immediately prior to approval of a variable rate by the county. A comparison of the updated screening and the previous screening must demonstrate an increase in resource needs.

(c) Rate adjustments projected to exceed the authorized funding level associated with the person's profile must be submitted to the commissioner.

(d) The new rate approved through this process shall not be averaged across all persons living at a facility but shall be an individual rate. The county of financial responsibility must indicate the projected length of time that the additional funding may be needed by the individual. The need to continue an individual variable rate must be reviewed at the end of the anticipated duration of need but at least annually through the completion of the developmental disabilities screening document.

Subd. 2. **Other payment rate adjustments.** Facility total payment rates may be adjusted by the host county, with authorization from a statewide advisory committee, if, through the local system needs planning process, it is determined that a need exists to amend the package of purchased services with a resulting increase or decrease in costs. Except as provided in section 252.292, subdivision 4, if a provider demonstrates that the loss of revenues caused by the downsizing or closure of a facility cannot be absorbed by the facility based on current operations, the host county or the provider may submit a request to the statewide advisory committee for a facility base rate adjustment.

Subd. 3. **Relocation.** (a) Property rates for all facilities relocated after December 31, 1997, and up to and including October 1, 2000, shall have the full annual costs of relocation

included in their October 1, 2000, property rate. The property rate for the relocated home is subject to the costs that were allowable under Minnesota Rules, chapter 9553, and the investment per bed limitation for newly constructed or newly established class B facilities.

(b) In ensuing years, all relocated homes shall be subject to the investment per bed limit for newly constructed or newly established class B facilities under section 256B.501, subdivision 11. The limits shall be adjusted on January 1 of each year by the percentage increase in the construction index published by the Bureau of Economic Analysis of the United States Department of Commerce in the Survey of Current Business Statistics in October of the previous two years. Facilities that are relocated within the investment per bed limit may be approved by the statewide advisory committee. Costs for relocation of a facility that exceed the investment per bed limit must be absorbed by the facility.

(c) The payment rate shall take effect when the new facility is licensed and certified by the commissioner of health. Rates for facilities that are relocated after December 31, 1997, through October 1, 2000, shall be adjusted to reflect the full inclusion of the relocation costs, subject to the investment per bed limit in paragraph (b). The investment per bed limit calculated rate for the year in which the facility was relocated shall be the investment per bed limit used.

Subd. 4. **Temporary rate adjustments to address occupancy and access.** If a facility is operating at less than 100 percent occupancy on September 30, 2000, or if a recipient is discharged from a facility, the commissioner shall adjust the total payment rate for up to 90 days for the remaining recipients. This mechanism shall not be used to pay for hospital or therapeutic leave days beyond the maximums allowed. Facility payment adjustments exceeding 90 days to address a demonstrated need for access must be submitted to the statewide advisory committee with a local system needs assessment, plan, and budget for review and recommendation.

History: *1999 c 245 art 3 s 34*

256B.5014 FINANCIAL REPORTING.

All facilities shall maintain financial records and shall provide annual income and expense reports to the commissioner of human services on a form prescribed by the commissioner no later than April 30 of each year in order to receive medical assistance payments. The reports for the reporting year ending December 31 must include:

(1) salaries and related expenses, including program salaries, administrative salaries, other salaries, payroll taxes, and fringe benefits;

(2) general operating expenses, including supplies, training, repairs, purchased services and consultants, utilities, food, licenses and fees, real estate taxes, insurance, and working capital interest;

(3) property related costs, including depreciation, capital debt interest, rent, and leases; and

(4) total annual resident days.

History: *1999 c 245 art 3 s 35*

256B.5015 PASS–THROUGH OF TRAINING AND HABILITATION SERVICES COSTS.

Training and habilitation services costs shall be paid as a pass–through payment at the lowest rate paid for the comparable services at that site under sections 252.40 to 252.46. The pass–through payments for training and habilitation services shall be paid separately by the commissioner and shall not be included in the computation of the total payment rate.

History: *1999 c 245 art 3 s 36*

256B.69 PREPAYMENT DEMONSTRATION PROJECT.

[For text of subds 1 to 3, see M.S.1998]

Subd. 3a. **County authority.** (a) The commissioner, when implementing the general assistance medical care, or medical assistance prepayment program within a county, must

include the county board in the process of development, approval, and issuance of the request for proposals to provide services to eligible individuals within the proposed county. County boards must be given reasonable opportunity to make recommendations regarding the development, issuance, review of responses, and changes needed in the request for proposals. The commissioner must provide county boards the opportunity to review each proposal based on the identification of community needs under chapters 145A and 256E and county advocacy activities. If a county board finds that a proposal does not address certain community needs, the county board and commissioner shall continue efforts for improving the proposal and network prior to the approval of the contract. The county board shall make recommendations regarding the approval of local networks and their operations to ensure adequate availability and access to covered services. The provider or health plan must respond directly to county advocates and the state prepaid medical assistance ombudsperson regarding service delivery and must be accountable to the state regarding contracts with medical assistance and general assistance medical care funds. The county board may recommend a maximum number of participating health plans after considering the size of the enrolling population; ensuring adequate access and capacity; considering the client and county administrative complexity; and considering the need to promote the viability of locally developed health plans. The county board or a single entity representing a group of county boards and the commissioner shall mutually select health plans for participation at the time of initial implementation of the prepaid medical assistance program in that county or group of counties and at the time of contract renewal. The commissioner shall also seek input for contract requirements from the county or single entity representing a group of county boards at each contract renewal and incorporate those recommendations into the contract negotiation process. The commissioner, in conjunction with the county board, shall actively seek to develop a mutually agreeable timetable prior to the development of the request for proposal, but counties must agree to initial enrollment beginning on or before January 1, 1999, in either the prepaid medical assistance and general assistance medical care programs or county–based purchasing under section 256B.692. At least 90 days before enrollment in the medical assistance and general assistance medical care prepaid programs begins in a county in which the prepaid programs have not been established, the commissioner shall provide a report to the chairs of senate and house committees having jurisdiction over state health care programs which verifies that the commissioner complied with the requirements for county involvement that are specified in this subdivision.

(b) The commissioner shall seek a federal waiver to allow a fee–for–service plan option to MinnesotaCare enrollees. The commissioner shall develop an increase of the premium fees required under section 256L.06 up to 20 percent of the premium fees for the enrollees who elect the fee–for–service option. Prior to implementation, the commissioner shall submit this fee schedule to the chair and ranking minority member of the senate health care committee, the senate health care and family services funding division, the house of representatives health and human services committee, and the house of representatives health and human services finance division.

(c) At the option of the county board, the board may develop contract requirements related to the achievement of local public health goals to meet the health needs of medical assistance and general assistance medical care enrollees. These requirements must be reasonably related to the performance of health plan functions and within the scope of the medical assistance and general assistance medical care benefit sets. If the county board and the commissioner mutually agree to such requirements, the department shall include such requirements in all health plan contracts governing the prepaid medical assistance and general assistance medical care programs in that county at initial implementation of the program in that county and at the time of contract renewal. The county board may participate in the enforcement of the contract provisions related to local public health goals.

(d) For counties in which prepaid medical assistance and general assistance medical care programs have not been established, the commissioner shall not implement those programs if a county board submits acceptable and timely preliminary and final proposals under section 256B.692, until county–based purchasing is no longer operational in that county. For counties in which prepaid medical assistance and general assistance medical care programs are in existence on or after September 1, 1997, the commissioner must terminate contracts

with health plans according to section 256B.692, subdivision 5, if the county board submits and the commissioner accepts preliminary and final proposals according to that subdivision. The commissioner is not required to terminate contracts that begin on or after September 1, 1997, according to section 256B.692 until two years have elapsed from the date of initial enrollment.

(e) In the event that a county board or a single entity representing a group of county boards and the commissioner cannot reach agreement regarding: (i) the selection of participating health plans in that county; (ii) contract requirements; or (iii) implementation and enforcement of county requirements including provisions regarding local public health goals, the commissioner shall resolve all disputes after taking into account the recommendations of a three-person mediation panel. The panel shall be composed of one designee of the president of the association of Minnesota counties, one designee of the commissioner of human services, and one designee of the commissioner of health.

(f) If a county which elects to implement county-based purchasing ceases to implement county-based purchasing, it is prohibited from assuming the responsibility of county-based purchasing for a period of five years from the date it discontinues purchasing.

(g) Notwithstanding the requirement in this subdivision that a county must agree to initial enrollment on or before January 1, 1999, the commissioner shall grant a delay in the implementation of the county-based purchasing authorized in section 256B.692 until federal waiver authority and approval has been granted, if the county or group of counties has submitted a preliminary proposal for county-based purchasing by September 1, 1997, has not already implemented the prepaid medical assistance program before January 1, 1998, and has submitted a written request for the delay to the commissioner by July 1, 1998. In order for the delay to be continued, the county or group of counties must also submit to the commissioner the following information by December 1, 1998. The information must:

(1) identify the proposed date of implementation, as determined under section 256B.692, subdivision 5;

(2) include copies of the county board resolutions which demonstrate the continued commitment to the implementation of county-based purchasing by the proposed date. County board authorization may remain contingent on the submission of a final proposal which meets the requirements of section 256B.692, subdivision 5, paragraph (b);

(3) demonstrate actions taken for the establishment of a governance structure between the participating counties and describe how the fiduciary responsibilities of county-based purchasing will be allocated between the counties, if more than one county is involved in the proposal;

(4) describe how the risk of a deficit will be managed in the event expenditures are greater than total capitation payments. This description must identify how any of the following strategies will be used:

(i) risk contracts with licensed health plans;

(ii) risk arrangements with providers who are not licensed health plans;

(iii) risk arrangements with other licensed insurance entities; and

(iv) funding from other county resources;

(5) include, if county-based purchasing will not contract with licensed health plans or provider networks, letters of interest from local providers in at least the categories of hospital, physician, mental health, and pharmacy which express interest in contracting for services. These letters must recognize any risk transfer identified in clause (4), item (ii); and

(6) describe the options being considered to obtain the administrative services required in section 256B.692, subdivision 3, clauses (3) and (5).

(h) For counties which receive a delay under this subdivision, the final proposals required under section 256B.692, subdivision 5, paragraph (b), must be submitted at least six months prior to the requested implementation date. Authority to implement county-based purchasing remains contingent on approval of the final proposal as required under section 256B.692.

(i) If the commissioner is unable to provide county-specific, individual-level fee-for-service claims to counties by June 4, 1998, the commissioner shall grant a delay under para-

graph (g) of up to 12 months in the implementation of county–based purchasing, and shall require implementation not later than January 1, 2000. In order to receive an extension of the proposed date of implementation under this paragraph, a county or group of counties must submit a written request for the extension to the commissioner by August 1, 1998, must submit the information required under paragraph (g) by December 1, 1998, and must submit a final proposal as provided under paragraph (h).

(j) Notwithstanding other requirements of this subdivision, the commissioner shall not require the implementation of the county–based purchasing authorized in section 256B.692 until six months after federal waiver approval has been obtained for county–based purchasing, if the county or counties have submitted the final plan as required in section 256B.692, subdivision 5. The commissioner shall allow the county or counties which submitted information under section 256B.692, subdivision 5, to submit supplemental or additional information which was not possible to submit by April 1, 1999. A county or counties shall continue to submit the required information and substantive detail necessary to obtain a prompt response and waiver approval. If amendments to the final plan are necessary due to the terms and conditions of the waiver approval, the commissioner shall allow the county or group of counties 60 days to make the necessary amendments to the final plan and shall not require implementation of the county–based purchasing until six months after the revised final plan has been submitted.

Subd. 3b. **Provision of data to county boards.** The commissioner, in consultation with representatives of county boards of commissioners shall identify program information and data necessary on an ongoing basis for county boards to: (1) make recommendations to the commissioner related to state purchasing under the prepaid medical assistance program; and (2) effectively administer county–based purchasing. This information and data must include, but is not limited to, county–specific, individual–level fee–for–service and prepaid health plan claims information.

[For text of subd 4, see M.S.1998]

Subd. 4b. **Individual education plan and individualized family service plan services.** The commissioner shall amend the federal waiver allowing the state to separate out individual education plan and individualized family service plan services for children enrolled in the prepaid medical assistance program and the MinnesotaCare program. Effective July 1, 1999, or upon federal approval, medical assistance coverage of eligible individual education plan and individualized family service plan services shall not be included in the capitated services for children enrolled in health plans through the prepaid medical assistance program and the MinnesotaCare program. Upon federal approval, local school districts shall bill the commissioner for these services, and claims shall be paid on a fee–for–service basis.

[For text of subd 5, see M.S.1998]

Subd. 5a. **Managed care contracts.** Managed care contracts under this section and sections 256L.12 and 256D.03, shall be entered into or renewed on a calendar year basis beginning January 1, 1996. Managed care contracts which were in effect on June 30, 1995, and set to renew on July 1, 1995, shall be renewed for the period July 1, 1995 through December 31, 1995 at the same terms that were in effect on June 30, 1995.

A prepaid health plan providing covered health services for eligible persons pursuant to chapters 256B, 256D, and 256L, is responsible for complying with the terms of its contract with the commissioner. Requirements applicable to managed care programs under chapters 256B, 256D, and 256L, established after the effective date of a contract with the commissioner take effect when the contract is next issued or renewed.

Subd. 5b. **Prospective reimbursement rates.** (a) For prepaid medical assistance and general assistance medical care program contract rates set by the commissioner under subdivision 5 and effective on or after January 1, 1998, capitation rates for nonmetropolitan counties shall on a weighted average be no less than 88 percent of the capitation rates for metropolitan counties, excluding Hennepin county. The commissioner shall make a pro rata adjustment in capitation rates paid to counties other than nonmetropolitan counties in order to make this provision budget neutral.

(b) For prepaid medical assistance program contract rates set by the commissioner under subdivision 5 and effective on or after January 1, 2001, capitation rates for nonmetropolitan counties shall, on a weighted average, be no less than 89 percent of the capitation rates for metropolitan counties, excluding Hennepin county.

Subd. 5c. **Medical education and research fund.** (a) Beginning in January 1999 and each year thereafter:

(1) the commissioner of human services shall transfer an amount equal to the reduction in the prepaid medical assistance and prepaid general assistance medical care payments resulting from clause (2), excluding nursing facility and elderly waiver payments, to the medical education and research fund established under section 62J.692;

(2) the county medical assistance and general assistance medical care capitation base rate prior to plan specific adjustments shall be reduced 6.3 percent for Hennepin county, two percent for the remaining metropolitan counties, and 1.6 percent for nonmetropolitan Minnesota counties; and

(3) the amount calculated under clause (1) shall not be adjusted for subsequent changes to the capitation payments for periods already paid.

(b) This subdivision shall be effective upon approval of a federal waiver which allows federal financial participation in the medical education and research fund.

[For text of subd 5d, see M.S.1998]

Subd. 5e. **Medical education and research payments.** For the calendar years 1999, 2000, and 2001, a hospital that participates in funding the federal share of the medical education and research trust fund payment under Laws 1998, chapter 407, article 1, section 3, shall not be held liable for any amounts attributable to this payment above the charge limit of section 256.969, subdivision 3a. The commissioner of human services shall assume liability for any corresponding federal share of the payments above the charge limit.

[For text of subd 6, see M.S.1998]

Subd. 6a. **Nursing home services.** (a) Notwithstanding Minnesota Rules, part 9500.1457, subpart 1, item B, up to 90 days of nursing facility services as defined in section 256B.0625, subdivision 2, which are provided in a nursing facility certified by the Minnesota department of health for services provided and eligible for payment under Medicaid, shall be covered under the prepaid medical assistance program for individuals who are not residing in a nursing facility at the time of enrollment in the prepaid medical assistance program.

(b) For individuals enrolled in the Minnesota senior health options project authorized under subdivision 23, nursing facility services shall be covered according to the terms and conditions of the federal agreement governing that demonstration project.

Subd. 6b. **Home and community–based waiver services.** (a) For individuals enrolled in the Minnesota senior health options project authorized under subdivision 23, elderly waiver services shall be covered according to the terms and conditions of the federal agreement governing that demonstration project.

(b) For individuals under age 65 with physical disabilities but without a primary diagnosis of mental illness or developmental disabilities, except for related conditions, enrolled in the Minnesota senior health options project authorized under subdivision 23, home and community–based waiver services shall be covered according to the terms and conditions of the federal agreement governing that demonstration project.

[For text of subds 7 to 23, see M.S.1998]

Subd. 24. MS 1997 SUPP [Repealed, 1999 c 245 art 3 s 51]

[For text of subds 24 to 27, see M.S.1998]

History: *1999 c 159 s 53; 1999 c 245 art 2 s 38; art 3 s 37,38; art 4 s 70–75*

NOTE: Subdivision 24, as enacted by Laws 1997, chapter 203, article 4, section 55, and repealed by Laws 1999, chapter 245, article 3, section 51, was inadvertently omitted from Minnesota Statutes 1998.

256B.692 COUNTY-BASED PURCHASING.

[For text of subd 1, see M.S.1998]

Subd. 2. **Duties of the commissioner of health.** (a) Notwithstanding chapters 62D and 62N, a county that elects to purchase medical assistance and general assistance medical care in return for a fixed sum without regard to the frequency or extent of services furnished to any particular enrollee is not required to obtain a certificate of authority under chapter 62D or 62N. The county board of commissioners is the governing body of a county-based purchasing program. In a multicounty arrangement, the governing body is a joint powers board established under section 471.59.

(b) A county that elects to purchase medical assistance and general assistance medical care services under this section must satisfy the commissioner of health that the requirements for assurance of consumer protection, provider protection, and fiscal solvency of chapter 62D, applicable to health maintenance organizations, or chapter 62N, applicable to community integrated service networks, will be met.

(c) A county must also assure the commissioner of health that the requirements of sections 62J.041; 62J.48; 62J.71 to 62J.73; 62M.01 to 62M.16; all applicable provisions of chapter 62Q, including sections 62Q.07; 62Q.075; 62Q.1055; 62Q.106; 62Q.12; 62Q.135; 62Q.14; 62Q.145; 62Q.19; 62Q.23, paragraph (c); 62Q.43; 62Q.47; 62Q.50; 62Q.52 to 62Q.56; 62Q.58; 62Q.64; 62Q.68 to 62Q.72; and 72A.201 will be met.

(d) All enforcement and rulemaking powers available under chapters 62D, 62J, 62M, 62N, and 62Q are hereby granted to the commissioner of health with respect to counties that purchase medical assistance and general assistance medical care services under this section.

(e) The commissioner, in consultation with county government, shall develop administrative and financial reporting requirements for county-based purchasing programs relating to sections 62D.041, 62D.042, 62D.045, 62D.08, 62N.28, 62N.29, and 62N.31, and other sections as necessary, that are specific to county administrative, accounting, and reporting systems and consistent with other statutory requirements of counties.

[For text of subds 3 to 10, see M.S.1998]

History: *1999 c 239 s 42; 1999 c 245 art 4 s 76*

NOTE: The amendment to subdivision 2 by Laws 1999, chapter 239, section 42, is effective April 1, 2000, and applies to contracts issued or renewed on or after that date. Upon request, the commissioner of health or commerce shall grant an extension of up to three months to any health plan company or utilization review organization that is unable to comply with Laws 1999, chapter 239, sections 1, 3 to 42, and 43, paragraphs (a) and (c), by April 1, 2000, and to circumstances beyond the control of the health plan company or utilization review organization. Laws 1999, chapter 239, section 44.

256B.74 SPECIAL PAYMENTS.

[For text of subd 1, see M.S.1998]

Subd. 2. [Repealed, 1999 c 245 art 4 s 120]

[For text of subds 3 and 4, see M.S.1998]

Subd. 5. [Repealed, 1999 c 245 art 4 s 120]

[For text of subds 6 to 10, see M.S.1998]

256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.

(a) For outpatient hospital facility fee payments for services rendered on or after October 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge, or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for which there is a federal maximum allowable payment. Effective for services rendered on or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and emergency room facility fees shall be increased by eight percent over the rates in effect on December 31, 1999, except for those services for which there is a federal maximum allowable payment. Services for which there is a federal maximum allowable payment shall be paid at the lower

of (1) submitted charge, or (2) the federal maximum allowable payment. Total aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare upper limit. If it is determined that a provision of this section conflicts with existing or future requirements of the United States government with respect to federal financial participation in medical assistance, the federal requirements prevail. The commissioner may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial participation resulting from rates that are in excess of the Medicare upper limitations.

(b) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory surgery hospital facility fee services for critical access hospitals designated under section 144.1483, clause (11), shall be paid on a cost–based payment system that is based on the cost–finding methods and allowable costs of the Medicare program.

History: *1999 c 245 art 4 s 77*

256B.76 PHYSICIAN AND DENTAL REIMBURSEMENT.

(a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for physician services as follows:

(1) payment for level one Health Care Finance Administration's common procedural coding system (HCPCS) codes titled "office and other outpatient services," "preventive medicine new and established patient," "delivery, antepartum, and postpartum care," "critical care," Caesarean delivery and pharmacologic management provided to psychiatric patients, and HCPCS level three codes for enhanced services for prenatal high risk, shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992. If the rate on any procedure code within these categories is different than the rate that would have been paid under the methodology in section 256B.74, subdivision 2, then the larger rate shall be paid;

(2) payments for all other services shall be paid at the lower of (i) submitted charges, or (ii) 15.4 percent above the rate in effect on June 30, 1992;

(3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases except that payment rates for home health agency services shall be the rates in effect on September 30, 1992;

(4) effective for services rendered on or after January 1, 2000, payment rates for physician and professional services shall be increased by three percent over the rates in effect on December 31, 1999, except for home health agency and family planning agency services; and

(5) the increases in clause (4) shall be implemented January 1, 2000, for managed care.

(b) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for dental services as follows:

(1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992;

(2) dental rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases;

(3) effective for services rendered on or after January 1, 2000, payment rates for dental services shall be increased by three percent over the rates in effect on December 31, 1999;

(4) the commissioner shall award grants to community clinics or other nonprofit community organizations, political subdivisions, professional associations, or other organizations that demonstrate the ability to provide dental services effectively to public program recipients. Grants may be used to fund the costs related to coordinating access for recipients, developing and implementing patient care criteria, upgrading or establishing new facilities, acquiring furnishings or equipment, recruiting new providers, or other development costs that will improve access to dental care in a region. In awarding grants, the commissioner shall give priority to applicants that plan to serve areas of the state in which the number of dental providers is not currently sufficient to meet the needs of recipients of public programs or uninsured individuals. The commissioner shall consider the following in awarding the grants: (i) potential to successfully increase access to an underserved population; (ii) the abil-

ity to raise matching funds; (iii) the long–term viability of the project to improve access beyond the period of initial funding; (iv) the efficiency in the use of the funding; and (v) the experience of the proposers in providing services to the target population.

The commissioner shall monitor the grants and may terminate a grant if the granteè does not increase dental access for public program recipients. The commissioner shall consider grants for the following:

(i) implementation of new programs or continued expansion of current access programs that have demonstrated success in providing dental services in underserved areas;

(ii) a pilot program for utilizing hygienists outside of a traditional dental office to provide dental hygiene services; and

(iii) a program that organizes a network of volunteer dentists, establishes a system to refer eligible individuals to volunteer dentists, and through that network provides donated dental care services to public program recipients or uninsured individuals.

(5) beginning October 1, 1999, the payment for tooth sealants and fluoride treatments shall be the lower of (i) submitted charge, or (ii) 80 percent of median 1997 charges; and

(6) the increases listed in clauses (3) and (5) shall be implemented January 1, 2000, for managed care.

(c) An entity that operates both a Medicare certified comprehensive outpatient rehabilitation facility and a facility which was certified prior to January 1, 1993, that is licensed under Minnesota Rules, parts 9570.2000 to 9570.3600, and for whom at least 33 percent of the clients receiving rehabilitation services in the most recent calendar year are medical assistance recipients, shall be reimbursed by the commissioner for rehabilitation services at rates that are 38 percent greater than the maximum reimbursement rate allowed under paragraph (a), clause (2), when those services are (1) provided within the comprehensive outpatient rehabilitation facility and (2) provided to residents of nursing facilities owned by the entity.

History: *1999 c 245 art 4 s 78*

256B.765 PROVIDER RATE INCREASES.

(a) Effective July 1, 2001, within the limits of appropriations specifically for this purpose, the commissioner shall provide an annual inflation adjustment for the providers listed in paragraph (c). The index for the inflation adjustment must be based on the change in the Employment Cost Index for Private Industry Workers – Total Compensation forecasted by Data Resources, Inc., as forecasted in the fourth quarter of the calendar year preceding the fiscal year. The commissioner shall increase reimbursement or allocation rates by the percentage of this adjustment, and county boards shall adjust provider contracts as needed.

(b) The commissioner of finance shall include an annual inflationary adjustment in reimbursement rates for the providers listed in paragraph (c) using the inflation factor specified in paragraph (a) as a budget change request in each biennial detailed expenditure budget submitted to the legislature under section 16A.11.

(c) The annual adjustment under paragraph (a) shall be provided for home and community–based waiver services for persons with mental retardation or related conditions under section 256B.501; home and community–based waiver services for the elderly under section 256B.0915; waivered services under community alternatives for disabled individuals under section 256B.49; community alternative care waivered services under section 256B.49; traumatic brain injury waivered services under section 256B.49; nursing services and home health services under section 256B.0625, subdivision 6a; personal care services and nursing supervision of personal care services under section 256B.0625, subdivision 19a; private duty nursing services under section 256B.0625, subdivision 7; day training and habilitation services for adults with mental retardation or related conditions under sections 252.40 to 252.46; physical therapy services under sections 256B.0625, subdivision 8, and 256D.03, subdivision 4; occupational therapy services under sections 256B.0625, subdivision 8a, and 256D.03, subdivision 4; speech–language therapy services under section 256D.03, subdivision 4, and Minnesota Rules, part 9505.0390; respiratory therapy services under section 256D.03, subdivision 4, and Minnesota Rules, part 9505.0295; alternative care services under section 256B.0913; adult residential program grants under Minnesota Rules, parts

9535.2000 to 9535.3000; adult and family community support grants under Minnesota Rules, parts 9535.1700 to 9535.1760; semi–independent living services under section 252.275 including SILS funding under county social services grants formerly funded under chapter 256I; and community support services for deaf and hard–of–hearing adults with mental illness who use or wish to use sign language as their primary means of communication.

History: *1999 c 245 art 4 s 79*

256B.77 COORDINATED SERVICE DELIVERY SYSTEM FOR PEOPLE WITH DISABILITIES.

[For text of subds 1 to 7, see M.S.1998]

Subd. 7a. **Eligible individuals.** (a) Persons are eligible for the demonstration project as provided in this subdivision.

(b) "Eligible individuals" means those persons living in the demonstration site who are eligible for medical assistance and are disabled based on a disability determination under section 256B.055, subdivisions 7 and 12, or who are eligible for medical assistance and have been diagnosed as having:

(1) serious and persistent mental illness as defined in section 245.462, subdivision 20;

(2) severe emotional disturbance as defined in section 245.4871, subdivision 6; or

(3) mental retardation, or being a mentally retarded person as defined in section 252A.02, or a related condition as defined in section 252.27, subdivision 1a.

Other individuals may be included at the option of the county authority based on agreement with the commissioner.

(c) Eligible individuals include individuals in excluded time status, as defined in chapter 256G. Enrollees in excluded time at the time of enrollment shall remain in excluded time status as long as they live in the demonstration site and shall be eligible for 90 days after placement outside the demonstration site if they move to excluded time status in a county within Minnesota other than their county of financial responsibility.

(d) A person who is a sexual psychopathic personality as defined in section 253B.02, subdivision 18a, or a sexually dangerous person as defined in section 253B.02, subdivision 18b, is excluded from enrollment in the demonstration project.

Subd. 7b. **American Indian recipients.** (a) Beginning on or after July 1, 1999, for American Indian recipients of medical assistance who are required to enroll with a county administrative entity or service delivery organization under subdivision 7, medical assistance shall cover health care services provided at American Indian health services facilities and facilities operated by a tribe or tribal organization under funding authorized by United States Code, title 25, sections 450f to 450n, or title III of the Indian Self–Determination and Education Assistance Act, Public Law Number 93–638, if those services would otherwise be covered under section 256B.0625. Payments for services provided under this subdivision shall be made on a fee–for–service basis, and may, at the option of the tribe or tribal organization, be made according to rates authorized under sections 256.969, subdivision 16, and 256B.0625, subdivision 34. Implementation of this purchasing model is contingent on federal approval.

(b) The commissioner of human services, in consultation with tribal governments, shall develop a plan for tribes to assist in the enrollment process for American Indian recipients enrolled in the demonstration project for people with disabilities under this section. This plan also shall address how tribes will be included in ensuring the coordination of care for American Indian recipients between Indian health service or tribal providers and other providers.

(c) For purposes of this subdivision, "American Indian" has the meaning given to persons to whom services will be provided for in Code of Federal Regulations, title 42, section 36.12.

Subd. 8. **Responsibilities of the county administrative entity.** (a) The county administrative entity shall meet the requirements of this subdivision, unless the county authority or the commissioner, with written approval of the county authority, enters into a service deliv-

ery contract with a service delivery organization for any or all of the requirements contained in this subdivision.

(b) The county administrative entity shall enroll eligible individuals regardless of health or disability status.

(c) The county administrative entity shall provide all enrollees timely access to the medical assistance benefit set. Alternative services and additional services are available to enrollees at the option of the county administrative entity and may be provided if specified in the personal support plan. County authorities are not required to seek prior authorization from the department as required by the laws and rules governing medical assistance.

(d) The county administrative entity shall cover necessary services as a result of an emergency without prior authorization, even if the services were rendered outside of the provider network.

(e) The county administrative entity shall authorize necessary and appropriate services when needed and requested by the enrollee or the enrollee's legal representative in response to an urgent situation. Enrollees shall have 24–hour access to urgent care services coordinated by experienced disability providers who have information about enrollees' needs and conditions.

(f) The county administrative entity shall accept the capitation payment from the commissioner in return for the provision of services for enrollees.

(g) The county administrative entity shall maintain internal grievance and complaint procedures, including an expedited informal complaint process in which the county administrative entity must respond to verbal complaints within ten calendar days, and a formal grievance process, in which the county administrative entity must respond to written complaints within 30 calendar days.

(h) The county administrative entity shall provide a certificate of coverage, upon enrollment, to each enrollee and the enrollee's legal representative, if any, which describes the benefits covered by the county administrative entity, any limitations on those benefits, and information about providers and the service delivery network. This information must also be made available to prospective enrollees. This certificate must be approved by the commissioner.

(i) The county administrative entity shall present evidence of an expedited process to approve exceptions to benefits, provider network restrictions, and other plan limitations under appropriate circumstances.

(j) The county administrative entity shall provide enrollees or their legal representatives with written notice of their appeal rights under subdivision 16, and of ombudsman and advocacy programs under subdivisions 13 and 14, at the following times: upon enrollment, upon submission of a written complaint, when a service is reduced, denied, or terminated, or when renewal of authorization for ongoing service is refused.

(k) The county administrative entity shall determine immediate needs, including services, support, and assessments, within 30 calendar days after enrollment, or within a shorter time frame if specified in the intergovernmental contract.

(l) The county administrative entity shall assess the need for services of new enrollees within 60 calendar days after enrollment, or within a shorter time frame if specified in the intergovernmental contract, and periodically reassess the need for services for all enrollees.

(m) The county administrative entity shall ensure the development of a personal support plan for each person within 60 calendar days of enrollment, or within a shorter time frame if specified in the intergovernmental contract, unless otherwise agreed to by the enrollee and the enrollee's legal representative, if any. Until a personal support plan is developed and agreed to by the enrollee, enrollees must have access to the same amount, type, setting, duration, and frequency of covered services that they had at the time of enrollment unless other covered services are needed. For an enrollee who is not receiving covered services at the time of enrollment and for enrollees whose personal support plan is being revised, access to the medical assistance benefit set must be assured until a personal support plan is developed or revised. If an enrollee chooses not to develop a personal support plan, the enrollee will be subject to the network and prior authorization requirements of the county administrative entity or service delivery organization 60 days after enrollment. An enrollee can choose

to have a personal support plan developed at any time. The personal support plan must be based on choices, preferences, and assessed needs and strengths of the enrollee. The service coordinator shall develop the personal support plan, in consultation with the enrollee or the enrollee's legal representative and other individuals requested by the enrollee. The personal support plan must be updated as needed or as requested by the enrollee. Enrollees may choose not to have a personal support plan.

(n) The county administrative entity shall ensure timely authorization, arrangement, and continuity of needed and covered supports and services.

(o) The county administrative entity shall offer service coordination that fulfills the responsibilities under subdivision 12 and is appropriate to the enrollee's needs, choices, and preferences, including a choice of service coordinator.

(p) The county administrative entity shall contract with schools and other agencies as appropriate to provide otherwise covered medically necessary medical assistance services as described in an enrollee's individual family support plan, as described in sections 125A.26 to 125A.48, or individual education plan, as described in chapter 125A.

(q) The county administrative entity shall develop and implement strategies, based on consultation with affected groups, to respect diversity and ensure culturally competent service delivery in a manner that promotes the physical, social, psychological, and spiritual well–being of enrollees and preserves the dignity of individuals, families, and their communities.

(r) When an enrollee changes county authorities, county administrative entities shall ensure coordination with the entity that is assuming responsibility for administering the medical assistance benefit set to ensure continuity of supports and services for the enrollee.

(s) The county administrative entity shall comply with additional requirements as specified in the intergovernmental contract.

(t) To the extent that alternatives are approved under subdivision 17, county administrative entities must provide for the health and safety of enrollees and protect the rights to privacy and to provide informed consent.

[For text of subd 9, see M.S.1998]

Subd. 10. **Capitation payment.** (a) The commissioner shall pay a capitation payment to the county authority and, when applicable under subdivision 6, paragraph (a), to the service delivery organization for each medical assistance eligible enrollee. The commissioner shall develop capitation payment rates for the initial contract period for each demonstration site in consultation with an independent actuary, to ensure that the cost of services under the demonstration project does not exceed the estimated cost for medical assistance services for the covered population under the fee–for–service system for the demonstration period. For each year of the demonstration project, the capitation payment rate shall be based on 96 percent of the projected per person costs that would otherwise have been paid under medical assistance fee–for–service during each of those years. Rates shall be adjusted within the limits of the available risk adjustment technology, as mandated by section 62Q.03. In addition, the commissioner shall implement appropriate risk and savings sharing provisions with county administrative entities and, when applicable under subdivision 6, paragraph (a), service delivery organizations within the projected budget limits. Capitation rates shall be adjusted, at least annually, to include any rate increases and payments for expanded or newly covered services for eligible individuals. The initial demonstration project rate shall include an amount in addition to the fee–for–service payments to adjust for underutilization of dental services. Any savings beyond those allowed for the county authority, county administrative entity, or service delivery organization shall be first used to meet the unmet needs of eligible individuals. Payments to providers participating in the project are exempt from the requirements of sections 256.966 and 256B.03, subdivision 2.

(b) The commissioner shall monitor and evaluate annually the effect of the discount on consumers, the county authority, and providers of disability services. Findings shall be reported and recommendations made, as appropriate, to ensure that the discount effect does not adversely affect the ability of the county administrative entity or providers of services to provide appropriate services to eligible individuals, and does not result in cost shifting of eligible individuals to the county authority.

(c) For risk–sharing to occur under this subdivision, the aggregate fee–for–service cost of covered services provided by the county administrative entity under this section must exceed the aggregate sum of capitation payments made to the county administrative entity under this section. The county authority is required to maintain its current level of nonmedical assistance spending on enrollees. If the county authority spends less in nonmedical assistance dollars on enrollees than it spent the year prior to the contract year, the amount of underspending shall be deducted from the aggregate fee–for–service cost of covered services. The commissioner shall then compare the fee–for–service costs and capitation payments related to the services provided for the term of this contract. The commissioner shall base its calculation of the fee–for–service costs on application of the medical assistance fee schedule to services identified on the county administrative entity's encounter claims submitted to the commissioner. The aggregate fee–for–service cost shall not include any third–party recoveries or cost–avoided amounts.

If the commissioner finds that the aggregate fee–for–service cost is greater than the sum of the capitation payments, the commissioner shall settle according to the following schedule:

(1) For the first contract year for each project, the commissioner shall pay the county administrative entity 50 percent of the difference between the sum of the capitation payments and 100 percent of projected fee–for–service costs. For aggregate fee–for–service costs in excess of 100 percent of projected fee–for–service costs, the commissioner shall pay 250 percent of the difference between the aggregate fee–for–service costs and the projected fee–for–service costs, up to 104 percent of the projected fee–for–service costs. The county administrative entity shall be responsible for all costs in excess of 104 percent of projected fee–for–service costs.

(2) For the second contract year for each project, the commissioner shall pay the county administrative entity 37.5 percent of the difference between the sum of the capitation payments and 100 percent of projected fee–for–service costs. The county administrative entity shall be responsible for all costs in excess of 100 percent of projected fee–for–service costs.

(3) For the third contract year for each project, the commissioner shall pay the county administrative entity 25 percent of the difference between the sum of the capitation payments and 100 percent of projected fee–for–service costs. The county administrative entity shall be responsible for all costs in excess of 100 percent of projected fee–for–service costs.

(4) For the fourth and subsequent contract years for each project, the county administrative entity shall be responsible for all costs in excess of the capitation payments.

(d) In addition to other payments under this subdivision, the commissioner may increase payments by up to 0.25 percent of the projected per person costs that would otherwise have been paid under medical assistance fee–for–service. The commissioner may make the increased payments to:

(1) offset rate increases for regional treatment services under subdivision 22 which are higher than was expected by the commissioner when the capitation was set at 96 percent; and

(2) implement incentives to encourage appropriate, high quality, efficient services.

[For text of subds 11 to 13, see M.S.1998]

Subd. 14. **External advocacy.** In addition to ombudsman services, enrollees shall have access to advocacy services on a local or regional basis. The purpose of external advocacy includes providing individual advocacy services for enrollees who have complaints or grievances with the county administrative entity, service delivery organization, or a service provider; assisting enrollees to understand the service delivery system and select providers and, if applicable, a service delivery organization; and understand and exercise their rights as an enrollee. External advocacy contractors must demonstrate that they have the expertise to advocate on behalf of eligible individuals and are independent of the commissioner, county authority, county administrative entity, service delivery organization, or any service provider within the demonstration project.

These advocacy services shall be provided through the ombudsman for mental health and mental retardation directly, or under contract with private, nonprofit organizations, with funding provided through the demonstration project. The funding shall be provided annually

to the ombudsman's office. Funding for external advocacy shall be provided through general fund appropriations. This funding is in addition to the capitation payment available under subdivision 10.

[For text of subds 15 to 26, see M.S.1998]

Subd. 27. **Service coordination transition.** Demonstration sites designated under subdivision 5, with the permission of an eligible individual, may implement the provisions of subdivision 12 beginning 60 calendar days prior to an individual's enrollment. This implementation may occur prior to the enrollment of eligible individuals, but is restricted to eligible individuals.

History: *1999 c 245 art 4 s 80–85*