CHAPTER 256B
MEDICAL ASSISTANCE FOR NEEDY PERSONS

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256B.001 MS 2006 [Renumbered 15.001]

256B.01 POLICY.

Medical assistance for needy persons whose resources are not adequate to meet the cost of such care is hereby declared to be a matter of state concern. To provide such care, a statewide program of medical assistance, with free choice of vendor, is hereby established.

History: *Ex1967 c 16 s 1*

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256B.011 POLICY FOR CHILDBIRTH AND ABORTION FUNDING.

Between normal childbirth and abortion it is the policy of the state of Minnesota that normal childbirth is to be given preference, encouragement and support by law and by state action, it being in the best interests of the well being and common good of Minnesota citizens.

History: *1978 c 508 s 1*

256B.0185 [Repealed, 2013 c 107 art 4 s 22]

256B.02 DEFINITIONS.

Subdivision 1. [Repealed, 1987 c 363 s 14]

Subd. 2. [Repealed, 1987 c 363 s 14]

Subd. 3. [Repealed, 1987 c 363 s 14]

Subd. 4. **Medical institution.** "Medical institution" means any licensed medical facility that receives a license from the Minnesota Health Department or Department of Human Services or appropriate licensing authority of this state, any other state, or a Canadian province.

Subd. 5. **State agency.** "State agency" means the commissioner of human services.

Subd. 6. **County agency.** "County agency" means a local social service agency operating under and pursuant to the provisions of chapter 393.

Subd. 7. **Vendor of medical care.** (a) "Vendor of medical care" means any person or persons furnishing, within the scope of the vendor's respective license, any or all of the following goods or services: medical, surgical, hospital, ambulatory surgical center services, optical, visual, dental and nursing services; drugs and medical supplies; appliances; laboratory, diagnostic, and therapeutic services; nursing home and convalescent care; screening and health assessment services provided by public health nurses as defined in section 145A.02, subdivision 18; health care services provided at the residence of the patient if the services are performed by a public health nurse and the nurse indicates in a statement submitted under oath that the services were actually provided; and such other medical services or supplies provided or prescribed by persons authorized by state law to give such services and supplies. The term includes, but is not limited to, directors and officers of corporations or members of partnerships who, either individually or jointly with another or others, have the legal control, supervision, or responsibility of submitting claims for reimbursement to the medical assistance program. The term only includes directors and officers of corporations who personally receive a portion of the distributed assets upon liquidation or dissolution, and their liability is limited to the portion of the claim that bears the same proportion to the total claim as their share of the distributed assets bears to the total distributed assets.

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

(c) A federally recognized Indian tribe that intends to implement standards for credentialing health professionals must submit the standards to the commissioner of human services, along with evidence of

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meeting, exceeding, or being exempt from corresponding state standards. The commissioner shall maintain a copy of the standards and supporting evidence, and shall use those standards to enroll tribal-approved health professionals as medical assistance providers. For purposes of this section, "Indian" and "Indian tribe" mean persons or entities that meet the definition in United States Code, title 25, section 450b.

Subd. 8. **Medical assistance; medical care.** "Medical assistance" or "medical care" means payment of part or all of the cost of the care and services identified in section 256B.0625, for eligible individuals whose income and resources are insufficient to meet all of this cost.

Subd. 8a. [Renumbered 256B.0625, subdivision 1]

Subd. 8b. [Renumbered 256B.0625, subd 2]

Subd. 8c. [Renumbered 256B.0625, subd 3]

Subd. 8d. [Renumbered 256B.0625, subd 4]

Subd. 8e. [Renumbered 256B.0625, subd 5]

Subd. 8f. [Renumbered 256B.0625, subd 6]

Subd. 8g. [Renumbered 256B.0625, subd 7]

Subd. 8h. [Renumbered 256B.0625, subd 8]

Subd. 8i. [Renumbered 256B.0625, subd 9]

Subd. 8j. [Renumbered 256B.0625, subd 10]

Subd. 8k. [Renumbered 256B.0625, subd 11]

Subd. 8l. [Renumbered 256B.0625, subd 12]

Subd. 8m. [Renumbered 256B.0625, subd 13]

Subd. 8n. [Renumbered 256B.0625, subd 14]

Subd. 8o. [Renumbered 256B.0625, subd 15]

Subd. 8p. [Renumbered 256B.0625, subd 16]

Subd. 8q. [Renumbered 256B.0625, subd 17]

Subd. 8r. [Renumbered 256B.0625, subd 18]

Subd. 8s. [Renumbered 256B.0625, subd 19]

Subd. 8t. [Renumbered 256B.0625, subd 20]

Subd. 8u. [Renumbered 256B.0625, subd 21]

Subd. 8v. [Renumbered 256B.0625, subd 22]

Subd. 8w. [Renumbered 256B.0625, subd 23]

Subd. 8x. [Renumbered 256B.0625, subd 24]

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Subd. 8y. [Renumbered 256B.0625, subd 25]

Subd. 9. **Private health care coverage.** "Private health care coverage" means any plan regulated by chapter 62A, 62C or 64B. Private health care coverage also includes any self-insured plan providing health care benefits, pharmacy benefit manager, service benefit plan, managed care organization, and other parties that are by contract legally responsible for payment of a claim for a health care item or service for an individual receiving medical benefits under chapter 256B, 256D, or 256L.

Subd. 10. **Automobile accident coverage.** "Automobile accident coverage" means any plan, or that portion of a plan, regulated under chapter 65B, which provides benefits for medical expenses incurred in an automobile accident.

Subd. 11. **Related condition.** "Related condition" means that condition defined in section 252.27, subdivision 1a.

Subd. 12. **Third-party payer.** "Third-party payer" means a person, entity, or agency or government program that has a probable obligation to pay all or part of the costs of a medical assistance recipient's health services. Third-party payer includes an entity under contract with the recipient to cover all or part of the recipient's medical costs.

Subd. 13. **Prepaid health plan.** "Prepaid health plan" means a vendor who receives a capitation payment and assumes financial risk for the provision of medical assistance services under a contract with the commissioner.

Subd. 14. **Group health plan.** "Group health plan" means any plan of, or contributed to by, an employer, including a self-insured plan, to provide health care directly or otherwise to the employer's employees, former employees, or the families of the employees or former employees, and includes continuation coverage pursuant to title XXII of the Public Health Service Act, section 4980B of the Internal Revenue Code of 1986, or title VI of the Employee Retirement Income Security Act of 1974.

Subd. 15. **Cost-effective.** "Cost-effective" means that the amount paid by the state for premiums, coinsurance, deductibles, other cost-sharing obligations under a health insurance plan, and other administrative costs is likely to be less than the amount paid for an equivalent set of services paid by medical assistance.

Subd. 16. **Termination; terminate.** "Termination" or "terminate" for a provider means a state Medicaid program, state children's health insurance program, or Medicare program has taken an action to revoke the provider's billing privileges, the provider has exhausted all appeal rights or the timeline for appeal has expired, there is no expectation by the provider, Medicaid program, state children's health insurance program, or Medicare program that the revocation is temporary, the provider will be required to reenroll to reinstate billing privileges, and the termination occurred for cause, including fraud, integrity, or quality.

Subd. 17. **Affordable Care Act.** "Affordable Care Act" means the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended, including the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any amendments to, and any federal guidance or regulations issued under, these acts.

Subd. 18. **Caretaker relative.** "Caretaker relative" means a relative, by blood, adoption, or marriage, of a child under age 19 with whom the child is living and who assumes primary responsibility for the child's care.

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Subd. 19. **Insurance affordability program.** "Insurance affordability program" means one of the following programs:

(1) medical assistance under this chapter;

(2) a program that provides advance payments of the premium tax credits established under section 36B of the Internal Revenue Code or cost-sharing reductions established under section 1402 of the Affordable Care Act;

(3) MinnesotaCare as defined in chapter 256L; and

(4) a Basic Health Plan as defined in section 1331 of the Affordable Care Act.

History: *Ex1967 c 16 s 2; 1969 c 395 s 1; 1973 c 717 s 17; 1975 c 247 s 9; 1975 c 384 s 1; 1975 c 437 art 2 s 3; 1976 c 173 s 56; 1976 c 236 s 1; 1976 c 312 s 1; 1978 c 508 s 2; 1978 c 560 s 10; 1981 c 360 art 2 s 26,54; 1Sp1981 c 2 s 12; 1Sp1981 c 4 art 4 s 22; 3Sp1981 c 2 art 1 s 31; 1982 c 562 s 2; 1983 c 151 s 1,2; 1983 c 312 art 1 s 27; art 5 s 10; art 9 s 4; 1984 c 654 art 5 s 58; 1985 c 21 s 52-54; 1985 c 49 s 41; 1985 c 252 s 19,20; 1Sp1985 c 3 s 19; 1986 c 394 s 17; 1986 c 444; 1987 c 370 art 1 s 3; art 2 s 4; 1987 c 374 s 1; 1987 c 309 s 24; 1987 c 403 art 2 s 73,74; art 5 s 16; 1988 c 689 art 2 s 141,268; 1992 c 464 art 1 s 55; 1992 c 513 art 7 s 31,32; 1994 c 631 s 31; 2002 c 275 s 2; 2004 c 198 s 17; 1Sp2005 c 4 art 8 s 17; 2006 c 282 art 17 s 24; 1Sp2011 c 9 art 6 s 22; 2013 c 1 s 1; 2013 c 108 art 1 s 5-7*

256B.021 MEDICAL ASSISTANCE REFORM WAIVER.

Subdivision 1. **Intent.** It is the intent of the legislature to reform components of the medical assistance program for seniors and people with disabilities or other complex needs, and medical assistance enrollees in general, in order to achieve better outcomes, such as community integration and independence; improved health; reduced reliance on institutional care; maintained or obtained employment and housing; and long-term sustainability of needed services through better alignment of available services that most effectively meet people's needs, including other state agencies' services.

Subd. 2. **Proposal.** The commissioner shall develop a proposal to the United States Department of Health and Human Services, which shall include any necessary waivers, state plan amendments, requests for new funding or realignment of existing funds, and any other federal authority that may be necessary for the projects specified in subdivision 4. The commissioner shall ensure all projects are budget neutral or result in savings to the state budget, considering cost changes across all divisions and other agencies that are affected.

Subd. 3. **Legislative proposals; rules.** The commissioner shall report to the members of the legislative committees having jurisdiction over human services issues by January 15, 2012, regarding the progress of this waiver, and make recommendations regarding any legislative changes necessary to accomplish the projects in subdivision 4.

Subd. 4. **Projects.** The commissioner shall request permission and funding to further the following initiatives.

(a) Health care delivery demonstration projects. This project involves testing alternative payment and service delivery models in accordance with sections 256B.0755 and 256B.0756. These demonstrations will allow the Minnesota Department of Human Services to engage in alternative payment arrangements with provider organizations that provide services to a specified patient population for an agreed upon total cost of care or risk/gain sharing payment arrangement, but are not limited to these models of care delivery or payment. Quality of care and patient experience will be measured and incorporated into payment models

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alongside the cost of care. Demonstration sites should include Minnesota health care programs fee-for-services recipients and managed care enrollees and support a robust primary care model and improved care coordination for recipients.

(b) Promote personal responsibility and encourage and reward healthy outcomes. This project provides Medicaid funding to provide individual and group incentives to encourage healthy behavior, prevent the onset of chronic disease, and reward healthy outcomes. Focus areas may include diabetes prevention and management, tobacco cessation, reducing weight, lowering cholesterol, and lowering blood pressure.

(c) Encourage utilization of high quality, cost-effective care. This project creates incentives through Medicaid and MinnesotaCare enrollee cost-sharing and other means to encourage the utilization of high-quality, low-cost, high-value providers, as determined by the state's provider peer grouping initiative under section 62U.04.

(d) Adults without children. This proposal includes requesting federal authority to impose a limit on assets for adults without children in medical assistance, as defined in section 256B.055, subdivision 15, who have a household income equal to or less than 75 percent of the federal poverty limit, and to impose a 180-day durational residency requirement in MinnesotaCare, consistent with section 256L.09, subdivision 4, for adults without children, regardless of income.

(e) Empower and encourage work, housing, and independence. This project provides services and supports for individuals who have an identified health or disabling condition but are not yet certified as disabled, in order to delay or prevent permanent disability, reduce the need for intensive health care and long-term care services and supports, and to help maintain or obtain employment or assist in return to work. Benefits may include:

(1) coordination with health care homes or health care coordinators;

(2) assessment for wellness, housing needs, employment, planning, and goal setting;

(3) training services;

(4) job placement services;

(5) career counseling;

(6) benefit counseling;

(7) worker supports and coaching;

(8) assessment of workplace accommodations;

(9) transitional housing services; and

(10) assistance in maintaining housing.

(f) Redesign home and community-based services. This project realigns existing funding, services, and supports for people with disabilities and older Minnesotans to ensure community integration and a more sustainable service system. This may involve changes that promote a range of services to flexibly respond to the following needs:

(1) provide people less expensive alternatives to medical assistance services;

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(2) offer more flexible and updated community support services under the Medicaid state plan;

(3) provide an individual budget and increased opportunity for self-direction;

(4) strengthen family and caregiver support services;

(5) allow persons to pool resources or save funds beyond a fiscal year to cover unexpected needs or foster development of needed services;

(6) use of home and community-based waiver programs for people whose needs cannot be met with the expanded Medicaid state plan community support service options;

(7) target access to residential care for those with higher needs;

(8) develop capacity within the community for crisis intervention and prevention;

(9) redesign case management;

(10) offer life planning services for families to plan for the future of their child with a disability;

(11) enhance self-advocacy and life planning for people with disabilities;

(12) improve information and assistance to inform long-term care decisions; and

(13) increase quality assurance, performance measurement, and outcome-based reimbursement.

This project may include different levels of long-term supports that allow seniors to remain in their homes and communities, and expand care transitions from acute care to community care to prevent hospitalizations and nursing home placement. The levels of support for seniors may range from basic community services for those with lower needs, access to residential services if a person has higher needs, and targets access to nursing home care to those with rehabilitation or high medical needs. This may involve the establishment of medical need thresholds to accommodate the level of support needed; provision of a long-term care consultation to persons seeking residential services, regardless of payer source; adjustment of incentives to providers and care coordination organizations to achieve desired outcomes; and a required coordination with medical assistance basic care benefit and Medicare/Medigap benefit. This proposal will improve access to housing and improve capacity to maintain individuals in their existing home; adjust screening and assessment tools, as needed; improve transition and relocation efforts; seek federal financial participation for alternative care and essential community supports; and provide Medigap coverage for people having lower needs.

(g) Coordinate and streamline services for people with complex needs, including those with multiple diagnoses of physical, mental, and developmental conditions. This project will coordinate and streamline medical assistance benefits for people with complex needs and multiple diagnoses. It would include changes that:

(1) develop community-based service provider capacity to serve the needs of this group;

(2) build assessment and care coordination expertise specific to people with multiple diagnoses;

(3) adopt service delivery models that allow coordinated access to a range of services for people with complex needs;

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(4) reduce administrative complexity;

(5) measure the improvements in the state's ability to respond to the needs of this population; and

(6) increase the cost-effectiveness for the state budget.

(h) Implement nursing home level of care criteria. This project involves obtaining any necessary federal approval in order to implement the changes to the level of care criteria in section 144.0724, subdivision 11, and implement further changes necessary to achieve reform of the home and community-based service system.

(i) Improve integration of Medicare and Medicaid. This project involves reducing fragmentation in the health care delivery system to improve care for people eligible for both Medicare and Medicaid, and to align fiscal incentives between primary, acute, and long-term care. The proposal may include:

(1) requesting an exception to the new Medicare methodology for payment adjustment for fully integrated special needs plans for dual eligible individuals;

(2) testing risk adjustment models that may be more favorable to capturing the needs of frail dually eligible individuals;

(3) requesting an exemption from the Medicare bidding process for fully integrated special needs plans for the dually eligible;

(4) modifying the Medicare bid process to recognize additional costs of health home services; and

(5) requesting permission for risk-sharing and gain-sharing.

(j) Intensive residential treatment services. This project would involve providing intensive residential treatment services for individuals who have serious mental illness and who have other complex needs. This proposal would allow such individuals to remain in these settings after mental health symptoms have stabilized, in order to maintain their mental health and avoid more costly or unnecessary hospital or other residential care due to their other complex conditions. The commissioner may pursue a specialized rate for projects created under this section.

(k) Seek federal Medicaid matching funds for Anoka Metro Regional Treatment Center (AMRTC). This project involves seeking Medicaid reimbursement for medical services provided to patients to AMRTC, including requesting a waiver of United States Code, title 42, section 1396d, which prohibits Medicaid reimbursement for expenditures for services provided by hospitals with more than 16 beds that are primarily focused on the treatment of mental illness. This waiver would allow AMRTC to serve as a statewide resource to provide diagnostics and treatment for people with the most complex conditions.

(l) Waivers to allow Medicaid eligibility for children under age 21 receiving care in residential facilities. This proposal would seek Medicaid reimbursement for any Medicaid-covered service for children who are placed in residential settings that are determined to be "institutions for mental diseases," under United States Code, title 42, section 1396d.

Subd. 4a. **Evaluation.** The commissioner shall evaluate the projects contained in subdivision 4, paragraphs (f), clauses (2) and (12), and (h). The evaluation must include:

(1) an impact assessment focusing on program outcomes, especially those experienced directly by the person receiving services;

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(2) study samples drawn from the population of interest for each project; and

(3) a time series analysis to examine aggregate trends in average monthly utilization, expenditures, and other outcomes in the targeted populations before and after implementation of the initiatives.

Subd. 5. **Federal funds.** The commissioner is authorized to accept and expend federal funds that support the purposes of this section.

Subd. 6. **Work, empower, and encourage independence.** As provided under subdivision 4, paragraph (e), upon federal approval, the commissioner shall establish a demonstration project to provide navigation, employment supports, and benefits planning services to a targeted group of federally funded Medicaid recipients to begin July 1, 2014. This demonstration shall promote economic stability, increase independence, and reduce applications for disability benefits while providing a positive impact on the health and future of participants.

Subd. 7. [Repealed, 2014 c 275 art 1 s 139]

History: *1Sp2011 c 9 art 7 s 53; 2012 c 187 art 1 s 36; 2013 c 108 art 1 s 67; art 2 s 14-16,44; art 15 s 3,4*

256B.03 PAYMENTS TO VENDORS.

Subdivision 1. **General limit.** All payments for medical assistance hereunder must be made to the vendor. The maximum payment for new vendors enrolled in the medical assistance program after the base year shall be determined from the average usual and customary charge of the same vendor type enrolled in the base year.

Subd. 2. [Repealed, 2000 c 449 s 15]

Subd. 3. **Tribal purchasing model.** (a) Notwithstanding subdivision 1 and sections 256B.0625 and 256D.03, subdivision 4, paragraph (l), the commissioner may make payments to federally recognized Indian tribes with a reservation in the state to provide medical assistance and general assistance medical care to Indians, as defined under federal law, who reside on or near the reservation. The payments may be made in the form of a block grant or other payment mechanism determined in consultation with the tribe. Any alternative payment mechanism agreed upon by the tribes and the commissioner under this subdivision is not dependent upon county or health plan agreement but is intended to create a direct payment mechanism between the state and the tribe for the administration of the medical assistance and general assistance medical care programs, and for covered services.

(b) A tribe that implements a purchasing model under this subdivision shall report to the commissioner at least annually on the operation of the model. The commissioner and the tribe shall cooperatively determine the data elements, format, and timetable for the report.

(c) For purposes of this subdivision, "Indian tribe" means a tribe, band, or nation, or other organized group or community of Indians that is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians and for which a reservation exists as is consistent with Public Law 100-485, as amended.

(d) Payments under this subdivision may not result in an increase in expenditures that would not otherwise occur in the medical assistance program under this chapter or the general assistance medical care program under chapter 256D.

[See Note.]

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Subd. 4. **Prohibition on payments to providers outside of the United States.** Payments for medical assistance must not be made:

(1) for services delivered or items supplied outside of the United States; or

(2) to a provider, financial institution, or entity located outside of the United States.

Subd. 5. **Ordering or referring providers.** Claims for payments for supplies or services that are based on an order or referral of a provider must include the ordering or referring provider's national provider identifier (NPI). Claims for supplies or services ordered or referred by a vendor who is not enrolled in medical assistance are not covered.

History: *Ex1967 c 16 s 3; 1981 c 360 art 2 s 27,54; 1Sp1981 c 2 s 13; 1Sp1981 c 4 art 4 s 22; 3Sp1982 c 1 art 2 s 4; 1983 c 312 art 1 s 27; 1987 c 384 art 2 s 63; 1987 c 403 art 2 s 75; 1996 c 451 art 5 s 14; 1998 c 407 art 4 s 11; 1Sp2011 c 9 art 6 s 23,24*

NOTE: Subdivision 3, as added by Laws 1996, chapter 451, article 5, section 14, is effective October 1, 1996, or upon receipt of any necessary federal approval, whichever date is later. Laws 1996, chapter 451, article 5, section 40.

256B.031 [Repealed, 2009 c 173 art 3 s 26]

256B.032 [Repealed, 2010 c 344 s 6]

256B.035 MANAGED CARE.

The commissioner of human services may contract with public or private entities or operate a preferred provider program to deliver health care services to medical assistance, general assistance medical care, and MinnesotaCare program recipients. The commissioner may enter into risk-based and non-risk-based contracts. Contracts may be for the full range of health services, or a portion thereof, for medical assistance and general assistance medical care populations to determine the effectiveness of various provider reimbursement and care delivery mechanisms. The commissioner may seek necessary federal waivers and implement projects when approval of the waivers is obtained from the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services.

History: *1990 c 568 art 3 s 20; 1992 c 513 art 7 s 33; 1995 c 234 art 8 s 56; 2002 c 277 s 32*

256B.037 PROSPECTIVE PAYMENT OF DENTAL SERVICES.

Subdivision 1. **Contract for dental services.** The commissioner may conduct a demonstration project to contract, on a prospective per capita payment basis, with an organization or organizations licensed under chapter 62C, 62D, or 62N for the provision of all dental care services beginning July 1, 1994, under the medical assistance, general assistance medical care, and MinnesotaCare programs, or when necessary waivers are granted by the secretary of health and human services, whichever occurs later. The commissioner shall identify a geographic area or areas, including both urban and rural areas, where access to dental services has been inadequate, in which to conduct demonstration projects. The commissioner shall seek any federal waivers or approvals necessary to implement this section from the secretary of health and human services.

The commissioner may exclude from participation in the demonstration project any or all groups currently excluded from participation in the prepaid medical assistance program under section 256B.69. Except for persons excluded from participation in the demonstration project, all persons who have been determined eligible for medical assistance, general assistance medical care and, if applicable, MinnesotaCare

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and reside in the designated geographic areas are required to enroll in a dental plan to receive their dental care services. Except for emergency services or out-of-plan services authorized by the dental plan, recipients must receive their dental services from dental care providers who are part of the dental plan provider network.

The commissioner shall select either multiple dental plans or a single dental plan in a designated area. A dental plan under contract with the department must serve both medical assistance recipients and general assistance medical care recipients in a designated geographic area and may serve MinnesotaCare recipients. The commissioner may limit the number of dental plans with which the department contracts within a designated geographic area, taking into consideration the number of recipients within the designated geographic area; the number of potential dental plan contractors; the size of the provider network offered by dental plans; the dental care services offered by a dental plan; qualifications of dental plan personnel; accessibility of services to recipients; dental plan assurances of recipient confidentiality; dental plan marketing and enrollment activities; dental plan compliance with this section; dental plan performance under other contracts with the department to serve medical assistance, general assistance medical care, or MinnesotaCare recipients; or any other factors necessary to provide the most economical care consistent with high standards of dental care.

For purposes of this section, "dental plan" means an organization licensed under chapter 62C, 62D, or 62N that contracts with the department to provide covered dental care services to recipients on a prepaid capitation basis. "Emergency services" has the meaning given in section 256B.0625, subdivision 4. "Multiple dental plan area" means a designated area in which more than one dental plan is offered. "Participating provider" means a dentist or dental clinic who is employed by or under contract with a dental plan to provide dental care services to recipients. "Single dental plan area" means a designated area in which only one dental plan is available.

Subd. 1a. **Multiple dental plan areas.** After the department has executed contracts with dental plans to provide covered dental care services in a multiple dental plan area, the department shall:

(1) inform applicants and recipients, in writing, of available dental plans, when written notice of dental plan selection must be submitted to the department, and when dental plan participation begins;

(2) assign to a dental plan recipients who fail to notify the department in writing of their dental plan choice; and

(3) notify recipients, in writing, of their assigned dental plan before the effective date of the recipient's dental plan participation.

Subd. 1b. **Single dental plan areas.** After the department has executed a contract with a dental plan to provide covered dental care services as the sole dental plan in a geographic area, the provisions in paragraphs (a) to (c) apply.

(a) The department shall assure that applicants and recipients are informed, in writing, of participating providers in the dental plan and when dental plan participation begins.

(b) The dental plan may require the recipient to select a specific dentist or dental clinic and may assign to a specific dentist or dental clinic recipients who fail to notify the dental plan of their selection.

(c) The dental plan shall notify recipients in writing of their assigned providers before the effective date of dental plan participation.

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Subd. 1c. **Dental choice.** (a) In multiple dental plan areas, recipients may change dental plans once within the first year the recipient participates in a dental plan. After the first year of dental plan participation, recipients may change dental plans during the annual 30-day open enrollment period.

(b) In single dental plan areas, recipients may change their specific dentist or clinic at least once during the first year of dental plan participation. After the first year of dental plan participation, recipients may change their specific dentist or clinic at least once annually. The dental plan shall notify recipients of this change option.

(c) If a dental plan's contract with the department is terminated for any reason, recipients in that dental plan shall select a new dental plan and may change dental plans or a specific dentist or clinic within the first 60 days of participation in the second dental plan.

(d) Recipients may change dental plans or a specific dentist or clinic at any time as follows:

(1) in multiple dental plan areas, if the travel time from the recipient's residence to a general practice dentist is over 30 minutes, the recipient may change dental plans;

(2) in single dental plan areas, if the travel time from the recipient's residence to the recipient's specific dentist or clinic is over 30 minutes, the recipient may change providers; or

(3) if the recipient's dental plan or specific dentist or clinic was incorrectly designated due to department or dental plan error.

(e) Requests for change under this subdivision must be submitted to the department or dental plan in writing. The department or dental plan shall notify recipients whether the request is approved or denied within 30 days after receipt of the written request.

Subd. 2. **Establishment of prepayment rates.** The commissioner shall consult with an independent actuary to establish prepayment rates, but shall retain final authority over the methodology used to establish the rates. The prepayment rates shall not result in payments that exceed the per capita expenditures that would have been made for dental services by the programs under a fee-for-service reimbursement system. The package of dental benefits provided to individuals under this subdivision shall not be less than the package of benefits provided under the medical assistance fee-for-service reimbursement system for dental services.

Subd. 3. **Appeals.** All recipients of services under this section have the right to appeal to the commissioner under section 256.045. A recipient participating in a dental plan may utilize the dental plan's internal complaint procedure but is not required to exhaust the internal complaint procedure before appealing to the commissioner. The appeal rights and procedures in Minnesota Rules, part 9500.1463, apply to recipients who enroll in dental plans.

Subd. 4. **Information required by commissioner.** A contractor shall submit encounter-specific information as required by the commissioner, including, but not limited to, information required for assessing client satisfaction, quality of care, and cost and utilization of services. Dental plans and participating providers must provide the commissioner access to recipient dental records to monitor compliance with the requirements of this section.

Subd. 5. **Other contracts permitted.** Nothing in this section prohibits the commissioner from contracting with an organization for comprehensive health services, including dental services, under section 256B.035, 256B.69, or 256D.03, subdivision 4, paragraph (c).

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Subd. 6. **Recipient costs.** A dental plan and its participating providers or nonparticipating providers who provide emergency services or services authorized by the dental plan shall not charge recipients for any costs for covered services.

Subd. 7. **Financial accountability.** A dental plan is accountable to the commissioner for the fiscal management of covered dental care services. The state of Minnesota and recipients shall be held harmless for the payment of obligations incurred by a dental plan if the dental plan or a participating provider becomes insolvent and the department has made the payments due to the dental plan under the contract.

Subd. 8. **Quality improvement.** A dental plan shall have an internal quality improvement system. A dental plan shall permit the commissioner or the commissioner's agents to evaluate the quality, appropriateness, and timeliness of covered dental care services through inspections, site visits, and review of dental records.

Subd. 9. **Third-party liability.** To the extent required under section 62A.046 and Minnesota Rules, part 9506.0080, a dental plan shall coordinate benefits for or recover the cost of dental care services provided recipients who have other dental care coverage. Coordination of benefits includes the dental plan paying applicable co-payments or deductibles on behalf of a recipient.

Subd. 10. **Financial capacity.** A dental plan shall demonstrate that its financial risk capacity is acceptable to its participating providers; except, an organization licensed as a health maintenance organization under chapter 62D, a nonprofit health service plan under chapter 62C, or a community integrated service network under chapter 62N, is not required to demonstrate financial risk capacity beyond the requirements in those chapters for licensure or a certificate of authority.

Subd. 11. **Data privacy.** The contract between the commissioner and the dental plan must specify that the dental plan is an agent of the welfare system and shall have access to welfare data on recipients to the extent necessary to carry out the dental plan's responsibilities under the contract. The dental plan shall comply with chapter 13, the Minnesota Government Data Practices Act.

History: *1Sp1993 c 1 art 5 s 27; 1995 c 234 art 6 s 22-33; 1997 c 203 art 9 s 9; 1997 c 225 art 2 s 62; 2009 c 173 art 3 s 5*

256B.038 PROVIDER RATE INCREASES AFTER JUNE 30, 1999.

(a) For fiscal years beginning on or after July 1, 1999, the commissioner of management and budget shall include an annual inflationary adjustment in payment rates for the services listed in paragraph (b) as a budget change request in each biennial detailed expenditure budget submitted to the legislature under section 16A.11. The adjustment shall be accomplished by indexing the rates in effect for inflation based on the change in the Consumer Price Index-All Items (United States city average)(CPI-U) as forecasted by Data Resources, Inc., in the fourth quarter of the prior year for the calendar year during which the rate increase occurs.

(b) Within the limits of appropriations specifically for this purpose, the commissioner shall apply the rate increases in paragraph (a) to home and community-based waiver services for persons with developmental disabilities 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; 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

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256B.0625, subdivision 19a; home care nursing services under section 256B.0625, subdivision 7; day training and habilitation services for adults with developmental disabilities under sections 252.41 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; physician services under section 256B.0625, subdivision 3; dental services under sections 256B.0625, subdivision 9, and 256D.03, subdivision 4; 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; and semi-independent living services under section 252.275, including SILS funding under county social services grants formerly funded under chapter 256I.

(c) The commissioner shall increase prepaid medical assistance program capitation rates as appropriate to reflect the rate increases in this section.

(d) In implementing this section, the commissioner shall consider proposing a schedule to equalize rates paid by different programs for the same service.

History: *1998 c 407 art 4 s 12; 2005 c 56 s 1; 2009 c 101 art 2 s 109; 2012 c 216 art 14 s 2; 2014 c 275 art 1 s 56; 2014 c 291 art 9 s 5*

256B.039 [Repealed, 2008 c 286 art 2 s 3]

256B.04 DUTIES OF STATE AGENCY.

Subdivision 1. **General.** The state agency shall supervise the administration of medical assistance for eligible recipients by the county agencies hereunder.

Subd. 1a. **Comprehensive health services system.** The commissioner shall carry out the duties in this section with the participation of the boards of county commissioners, and with full consideration for the interests of counties, to plan and implement a unified, accountable, comprehensive health services system that:

(1) promotes accessible and quality health care for all Minnesotans;

(2) assures provision of adequate health care within limited state and county resources;

(3) avoids shifting funding burdens to county tax resources;

(4) provides statewide eligibility, benefit, and service expectations;

(5) manages care, develops risk management strategies, and contains cost in all health and human services; and

(6) supports effective implementation of publicly funded health and human services for all areas of the state.

Subd. 1b. **Contract for administrative services for American Indian children.** Notwithstanding subdivision 1, the commissioner may contract with federally recognized Indian tribes with a reservation in

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

Subd. 2. **Rulemaking authority.** Make uniform rules, not inconsistent with law, for carrying out and enforcing the provisions hereof in an efficient, economical, and impartial manner, and to the end that the medical assistance system may be administered uniformly throughout the state, having regard for varying costs of medical care in different parts of the state and the conditions in each case, and in all things to carry out the spirit and purpose of this program, which rules shall be furnished immediately to all county agencies, and shall be binding on such county agencies.

Subd. 3. **Required forms.** Prescribe the form of, print, and supply to the county agencies, blanks for applications, reports, affidavits, and such other forms as it may deem necessary or advisable.

Subd. 4. **Cooperation with federal agency.** Cooperate with the federal Centers for Medicare and Medicaid Services in any reasonable manner as may be necessary to qualify for federal aid in connection with the medical assistance program, including the making of such reports in such form and containing such information as the Department of Health, Education, and Welfare may, from time to time, require, and comply with such provisions as such department may, from time to time, find necessary to assure the correctness and verifications of such reports.

Subd. 4a. **Medicare prescription drug subsidy.** The commissioner shall perform all duties necessary to administer eligibility determinations for the Medicare Part D prescription drug subsidy and facilitate the enrollment of eligible medical assistance recipients into Medicare prescription drug plans as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Public Law 108-173, and Code of Federal Regulations, title 42, sections 423.30 to 423.56 and 423.771 to 423.800.

Subd. 5. **Annual report required.** The state agency within 60 days after the close of each fiscal year, shall prepare and print for the fiscal year a report that includes a full account of the operations and expenditure of funds under this chapter, a full account of the activities undertaken in accordance with subdivision 10, adequate and complete statistics divided by counties about all medical assistance provided in accordance with this chapter, and any other information it may deem advisable.

Subd. 6. **Monthly statement.** Prepare and release a summary statement monthly showing by counties the amount paid hereunder and the total number of persons assisted.

Subd. 7. **Program safeguards.** Establish and enforce safeguards to prevent unauthorized disclosure or improper use of the information contained in applications, reports of investigations and medical examinations, and correspondence in the individual case records of recipients of medical assistance.

Subd. 8. **Information.** Furnish information to acquaint needy persons and the public generally with the plan for medical assistance of this state.

Subd. 9. **Reciprocal agreements.** Cooperate with agencies in other states in establishing reciprocal agreements to provide for payment of medical assistance to recipients who have moved to another state,

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consistent with the provisions hereof and of Title XIX of the Social Security Act of the United States of America.

Subd. 10. **Investigation of certain claims.** Establish by rule general criteria and procedures for the identification and prompt investigation of suspected medical assistance fraud, theft, abuse, presentment of false or duplicate claims, presentment of claims for services not medically necessary, or false statement or representation of material facts by a vendor of medical care, and for the imposition of sanctions against a vendor of medical care. If it appears to the state agency that a vendor of medical care may have acted in a manner warranting civil or criminal proceedings, it shall so inform the attorney general in writing.

Subd. 11. [Repealed, 1997 c 7 art 2 s 67]

Subd. 12. **Limitation on services.** (a) Place limits on the types of services covered by medical assistance, the frequency with which the same or similar services may be covered by medical assistance for an individual recipient, and the amount paid for each covered service. The state agency shall promulgate rules establishing maximum reimbursement rates for emergency and nonemergency transportation.

The rules shall provide:

(1) an opportunity for all recognized transportation providers to be reimbursed for nonemergency transportation consistent with the maximum rates established by the agency;

(2) reimbursement of public and private nonprofit providers serving the disabled population generally at reasonable maximum rates that reflect the cost of providing the service regardless of the fare that might be charged by the provider for similar services to individuals other than those receiving medical assistance or medical care under this chapter; and

(3) reimbursement for each additional passenger carried on a single trip at a substantially lower rate than the first passenger carried on that trip.

(b) The commissioner shall encourage providers reimbursed under this chapter to coordinate their operation with similar services that are operating in the same community. To the extent practicable, the commissioner shall encourage eligible individuals to utilize less expensive providers capable of serving their needs.

(c) For the purpose of this subdivision and section 256B.02, subdivision 8, and effective on January 1, 1981, "recognized provider of transportation services" means an operator of special transportation service as defined in section 174.29 that has been issued a current certificate of compliance with operating standards of the commissioner of transportation or, if those standards do not apply to the operator, that the agency finds is able to provide the required transportation in a safe and reliable manner. Until January 1, 1981, "recognized transportation provider" includes an operator of special transportation service that the agency finds is able to provide the required transportation in a safe and reliable manner.

Subd. 13. **Medical necessity review.** Each person appointed by the commissioner to participate in decisions whether medical care to be provided to eligible recipients is medically necessary shall abstain from participation in those cases in which the appointee (1) has issued treatment orders in the care of the patient or participated in the formulation or execution of the patient's treatment plan or (2) has, or a member of the appointee's family has, an ownership interest of five percent or more in the institution that provided or proposed to provide the services being reviewed.

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Subd. 14. **Competitive bidding.** (a) When determined to be effective, economical, and feasible, the commissioner may utilize volume purchase through competitive bidding and negotiation under the provisions of chapter 16C, to provide items under the medical assistance program including but not limited to the following:

(1) eyeglasses;

(2) oxygen. The commissioner shall provide for oxygen needed in an emergency situation on a short-term basis, until the vendor can obtain the necessary supply from the contract dealer;

(3) hearing aids and supplies; and

(4) durable medical equipment, including but not limited to:

(i) hospital beds;

(ii) commodes;

(iii) glide-about chairs;

(iv) patient lift apparatus;

(v) wheelchairs and accessories;

(vi) oxygen administration equipment;

(vii) respiratory therapy equipment;

(viii) electronic diagnostic, therapeutic and life-support systems;

(5) nonemergency medical transportation level of need determinations, disbursement of public transportation passes and tokens, and volunteer and recipient mileage and parking reimbursements; and

(6) drugs.

(b) Rate changes and recipient cost-sharing under this chapter and chapters 256D and 256L do not affect contract payments under this subdivision unless specifically identified.

(c) The commissioner may not utilize volume purchase through competitive bidding and negotiation for special transportation services under the provisions of chapter 16C.

Subd. 14a. **Level of need determination.** Nonemergency medical transportation level of need determinations must be performed by a physician, a registered nurse working under direct supervision of a physician, a physician assistant, a nurse practitioner, a licensed practical nurse, or a discharge planner. Nonemergency medical transportation level of need determinations must not be performed more than annually on any individual, unless the individual's circumstances have sufficiently changed so as to require a new level of need determination. Individuals residing in licensed nursing facilities are exempt from a level of need determination and are eligible for special transportation services until the individual no longer resides in a licensed nursing facility. If a person authorized by this subdivision to perform a level of need determination determines that an individual requires stretcher transportation, the individual is presumed to maintain that

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level of need until otherwise determined by a person authorized to perform a level of need determination, or for six months, whichever is sooner.

Subd. 15. **Utilization review.** (a) Establish on a statewide basis a new program to safeguard against unnecessary or inappropriate use of medical assistance services, against excess payments, against unnecessary or inappropriate hospital admissions or lengths of stay, and against underutilization of services in prepaid health plans, long-term care facilities or any health care delivery system subject to fixed rate reimbursement. In implementing the program, the state agency shall utilize both prepayment and postpayment review systems to determine if utilization is reasonable and necessary. The determination of whether services are reasonable and necessary shall be made by the commissioner in consultation with a professional services advisory group or health care consultant appointed by the commissioner.

(b) Contracts entered into for purposes of meeting the requirements of this subdivision shall not be subject to the set-aside provisions of chapter 16C.

(c) A recipient aggrieved by the commissioner's termination of services or denial of future services may appeal pursuant to section 256.045. A vendor aggrieved by the commissioner's determination that services provided were not reasonable or necessary may appeal pursuant to the contested case procedures of chapter 14. To appeal, the vendor shall notify the commissioner in writing within 30 days of receiving the commissioner's notice. The appeal request shall specify each disputed item, the reason for the dispute, an estimate of the dollar amount involved for each disputed item, the computation that the vendor believes is correct, the authority in statute or rule upon which the vendor relies for each disputed item, the name and address of the person or firm with whom contacts may be made regarding the appeal, and other information required by the commissioner.

(d) The commissioner may select providers to provide case management services to recipients who use health care services inappropriately or to recipients who are eligible for other managed care projects. The providers shall be selected based upon criteria that may include a comparison with a peer group of providers related to the quality, quantity, or cost of health care services delivered or a review of sanctions previously imposed by health care services programs or the provider's professional licensing board.

Subd. 16. [Repealed, 2014 c 262 art 4 s 9]

Subd. 17. **Prenatal care outreach.** (a) The commissioner of human services shall award a grant to an eligible organization to conduct a statewide media campaign promoting early prenatal care. The goals of the campaign are to increase public awareness of the importance of early and continuous prenatal care and to inform the public about public and private funds available for prenatal care.

(b) In order to receive a grant under this section, an applicant must:

(1) have experience conducting prenatal care outreach;

(2) have an established statewide constituency or service area; and

(3) demonstrate an ability to accomplish the purposes in this subdivision.

(c) Money received under this subdivision may be used for purchase of materials and supplies, staff fees and salaries, consulting fees, and other goods and services necessary to accomplish the goals of the campaign. Money may not be used for capital expenditures.

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Subd. 18. **Applications for medical assistance.** (a) The state agency shall accept applications for medical assistance by telephone, via mail, in-person, online via an Internet Web site, and through other commonly available electronic means.

(b) The commissioner of human services shall modify the Minnesota health care programs application form to add a question asking applicants whether they have ever served in the United States military.

(c) For each individual who submits an application or whose eligibility is subject to renewal or whose eligibility is being redetermined pursuant to a change in circumstances, if the agency determines the individual is not eligible for medical assistance, the agency shall determine potential eligibility for other insurance affordability programs.

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.

Subd. 20. **Money Follows the Person Rebalancing demonstration project.** In accordance with federal law governing Money Follows the Person Rebalancing funds, amounts equal to the value of enhanced federal funding resulting from the operation of the demonstration project grant must be transferred from the medical assistance account in the general fund to an account in the special revenue fund. Funds in the special revenue fund account do not cancel and are appropriated to the commissioner to carry out the goals of the Money Follows the Person Rebalancing demonstration project as required under the approved federal plan for the use of the funds, and may be transferred to the medical assistance account if applicable.

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

(b) An enrolled provider that is also licensed by the commissioner under chapter 245A, or is licensed as a home care provider by the Department of Health under chapter 144A and has a home and community-based services designation on the home care license under section 144A.484, must designate an individual as the entity's compliance officer. The compliance officer must:

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

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

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

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

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

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

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

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

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

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

(f) As a condition of enrollment in medical assistance, the commissioner shall require that a high-risk provider, or a person with a direct or indirect ownership interest in the provider of five percent or higher, consent to criminal background checks, including fingerprinting, when required to do so under state law or by a determination by the commissioner or the Centers for Medicare and Medicaid Services that a provider is designated high-risk for fraud, waste, or abuse.

(g)(1) Upon initial enrollment, reenrollment, and notification of revalidation, all durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) medical suppliers meeting the durable medical equipment provider and supplier definition in clause (3), operating in Minnesota and receiving Medicaid funds must purchase a surety bond that is annually renewed and designates the Minnesota Department of Human Services as the obligee, and must be submitted in a form approved by the commissioner. For purposes of this clause, the following medical suppliers are not required to obtain a surety bond: a federally qualified health center, a home health agency, the Indian Health Service, a pharmacy, and a rural health clinic.

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(2) At the time of initial enrollment or reenrollment, durable medical equipment providers and suppliers defined in clause (3) must purchase a surety bond of $50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is up to and including $300,000, the provider agency must purchase a surety bond of $50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is over $300,000, the provider agency must purchase a surety bond of $100,000. The surety bond must allow for recovery of costs and fees in pursuing a claim on the bond.

(3) "Durable medical equipment provider or supplier" means a medical supplier that can purchase medical equipment or supplies for sale or rental to the general public and is able to perform or arrange for necessary repairs to and maintenance of equipment offered for sale or rental.

(h) The Department of Human Services may require a provider to purchase a surety bond as a condition of initial enrollment, reenrollment, reinstatement, or continued enrollment if: (1) the provider fails to demonstrate financial viability, (2) the department determines there is significant evidence of or potential for fraud and abuse by the provider, or (3) the provider or category of providers is designated high-risk pursuant to paragraph (a) and as per Code of Federal Regulations, title 42, section 455.450. The surety bond must be in an amount of $100,000 or ten percent of the provider's payments from Medicaid during the immediately preceding 12 months, whichever is greater. The surety bond must name the Department of Human Services as an obligee and must allow for recovery of costs and fees in pursuing a claim on the bond. This paragraph does not apply if the provider currently maintains a surety bond under the requirements in section 256B.0659 or 256B.85.

Subd. 22. **Application fee.** (a) The commissioner must collect and retain federally required nonrefundable application fees to pay for provider screening activities in accordance with Code of Federal Regulations, title 42, section 455, subpart E. The enrollment application must be made under the procedures specified by the commissioner, in the form specified by the commissioner, and accompanied by an application fee described in paragraph (b), or a request for a hardship exception as described in the specified procedures. Application fees must be deposited in the provider screening account in the special revenue fund. Amounts in the provider screening account are appropriated to the commissioner for costs associated with the provider screening activities required in Code of Federal Regulations, title 42, section 455, subpart E. The commissioner shall conduct screening activities as required by Code of Federal Regulations, title 42, section 455, subpart E, and as otherwise provided by law, to include database checks, unannounced pre- and postenrollment site visits, fingerprinting, and criminal background studies. The commissioner must revalidate all providers under this subdivision at least once every five years.

(b) The application fee under this subdivision is $532 for the calendar year 2013. For calendar year 2014 and subsequent years, the fee:

(1) is adjusted by the percentage change to the Consumer Price Index for all urban consumers, United States city average, for the 12-month period ending with June of the previous year. The resulting fee must be announced in the Federal Register;

(2) is effective from January 1 to December 31 of a calendar year;

(3) is required on the submission of an initial application, an application to establish a new practice location, an application for reenrollment when the provider is not enrolled at the time of application of reenrollment, or at revalidation when required by federal regulation; and

(4) must be in the amount in effect for the calendar year during which the application for enrollment, new practice location, or reenrollment is being submitted.

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(c) The application fee under this subdivision cannot be charged to:

(1) providers who are enrolled in Medicare or who provide documentation of payment of the fee to, and enrollment with, another state, unless the commissioner is required to rescreen the provider;

(2) providers who are enrolled but are required to submit new applications for purposes of reenrollment;

(3) a provider who enrolls as an individual; and

(4) group practices and clinics that bill on behalf of individually enrolled providers within the practice who have reassigned their billing privileges to the group practice or clinic.

Subd. 23. **Medical assistance costs for certain inmates.** The commissioner shall execute an interagency agreement with the commissioner of corrections to recover the state cost attributable to medical assistance eligibility for inmates of public institutions admitted to a medical institution on an inpatient basis. The annual amount to be transferred from the Department of Corrections under the agreement must include all eligible state medical assistance costs, including administrative costs incurred by the Department of Human Services, attributable to inmates under state and county jurisdiction admitted to medical institutions on an inpatient basis that are related to the implementation of section 256B.055, subdivision 14, paragraph (c).

Subd. 24. **Medicaid waiver requests and state plan amendments.** Prior to submitting any Medicaid waiver request or Medicaid state plan amendment to the federal government for approval, the commissioner shall publish the text of the waiver request or state plan amendment, and a summary of and explanation of the need for the request, on the agency's Web site and provide a 30-day public comment period. The commissioner shall notify the public of the availability of this information through the agency's electronic subscription service. The commissioner shall consider public comments when preparing the final waiver request or state plan amendment that is to be submitted to the federal government for approval. The commissioner shall also publish on the agency's Web site notice of any federal decision related to the state request for approval, within 30 days of the decision. This notice must describe any modifications to the state request that have been agreed to by the commissioner as a condition of receiving federal approval.

History: *Ex1967 c 16 s 4; 1976 c 273 s 1-3; 1977 c 185 s 1; 1977 c 347 s 39,40; 1978 c 560 s 11; Ex1979 c 1 s 46; 1980 c 349 s 3,4; 1982 c 640 s 3; 1983 c 312 art 5 s 11,12; 1984 c 640 s 32; 1985 c 248 s 70; 1Sp1985 c 9 art 2 s 37; 1986 c 444; 1987 c 378 s 15; 1987 c 403 art 2 s 77,78; 1988 c 532 s 13; 1989 c 282 art 3 s 41,42; 1990 c 568 art 3 s 21,22; 1991 c 292 art 7 s 8; 1Sp1993 c 1 art 5 s 28; 1995 c 233 art 2 s 56; 1995 c 234 art 6 s 34; 1997 c 7 art 1 s 101; 1997 c 203 art 4 s 18; 1998 c 386 art 2 s 78,79; 1998 c 407 art 5 s 2; 1999 c 245 art 4 s 26,27; 1Sp2001 c 9 art 2 s 14; 2002 c 277 s 32; 2002 c 379 art 1 s 113; 2005 c 56 s 1; 2005 c 98 art 2 s 1; 1Sp2005 c 4 art 8 s 18; 2007 c 147 art 5 s 6,7; 2008 c 277 art 1 s 35; 2009 c 79 art 6 s 6; 1Sp2010 c 1 art 16 s 4; 1Sp2011 c 9 art 6 s 25,26; art 7 s 4; 2012 c 216 art 13 s 2; art 17 s 4; 2013 c 108 art 1 s 8; art 5 s 6,7; art 6 s 5; 2014 c 291 art 4 s 58; art 10 s 2; 2014 c 312 art 23 s 8; art 24 s 27*

256B.041 CENTRALIZED DISBURSEMENT OF MEDICAL ASSISTANCE PAYMENTS.

Subdivision 1. **Statewide disbursement system.** The state agency shall establish on a statewide basis a system for the centralized disbursement of medical assistance payments to vendors.

Subd. 2. **Account.** An account is established in the state treasury from which medical assistance payments to vendors shall be made. Into this account there shall be deposited federal funds, state funds, county funds, and other moneys which are available and which may be paid to the state agency for medical assistance payments and reimbursements from counties or others for their share of such payments.

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Subd. 3. **Vendor forms.** The state agency shall prescribe and furnish vendors suitable forms for submitting claims under the medical assistance program.

Subd. 4. **Comply with federal requirements.** The state agency in establishing a statewide system of centralized disbursement of medical assistance payments shall comply with federal requirements in order to receive the maximum amount of federal funds which are available for the purpose, together with such additional federal funds which may be made available for the operation of a centralized system of disbursement of medical assistance payments to vendors.

Subd. 5. [Repealed, 2010 c 382 s 87]

Subd. 6. **Contracted services.** The commissioners of human services and administration may contract with any agency of government or any corporation for providing all or a portion of the services for carrying out the provisions of this section. Local welfare agencies may pay vendors of transportation for nonemergency medical care when so authorized by rule of the commissioner of human services.

Subd. 7. **Disbursement of federal funds.** Federal funds available for administrative purposes shall be distributed between the state and the county on the same basis that reimbursements are earned, except as provided for under section 256.017.

History: *1973 c 717 s 2; 1975 c 437 art 2 s 4; 1978 c 560 s 12; 1983 c 312 art 5 s 13,14; 1984 c 654 art 5 s 58; 1985 c 248 s 70; 1988 c 719 art 8 s 11,12; 1989 c 277 art 2 s 7; 1Sp1989 c 1 art 16 s 6; 2002 c 277 s 9; 2003 c 112 art 2 s 50; 2009 c 101 art 2 s 109*

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 (c), 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

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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. **Attorney general representation.** 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 (c), 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.

Subd. 4. **Notice.** The state agency must be given notice of monetary claims against a person, firm, or corporation that may be liable to pay part or all of the cost of medical care when the state agency has paid or become liable for the cost of that care. Notice must be given as follows:

(a) Applicants for medical assistance shall notify the state or local agency of any possible claims when they submit the application. Recipients of medical assistance shall notify the state or local agency of any possible claims when those claims arise.

(b) A person providing medical care services to a recipient of medical assistance shall notify the state agency when the person has reason to believe that a third party may be liable for payment of the cost of medical care.

(c) A party to a claim upon which the state agency may be entitled to a lien under this section shall notify the state agency of its potential lien claim at each of the following stages of a claim:

(1) when a claim is filed;

(2) when an action is commenced; and

(3) when a claim is concluded by payment, award, judgment, settlement, or otherwise.

Every party involved in any stage of a claim under this subdivision is required to provide notice to the state agency at that stage of the claim. However, when one of the parties to the claim provides notice at that stage, every other party to the claim is deemed to have provided the required notice at that stage of the claim. If the required notice under this paragraph is not provided to the state agency, all parties to the claim are deemed to have failed to provide the required notice. A party to a claim includes the injured person or the person's legal representative, the plaintiff, the defendants, or persons alleged to be responsible for compensating the

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injured person or plaintiff, and any other party to the cause of action or claim, regardless of whether the party knows the state agency has a potential or actual lien claim.

Notice given to the local agency is not sufficient to meet the requirements of paragraphs (b) and (c).

Subd. 5. **Costs deducted.** Upon any judgment, award, or settlement of a cause of action, or any part of it, upon which the state agency has filed its lien, including compensation for liquidated, unliquidated, or other damages, reasonable costs of collection, including attorney fees, must be deducted first. The full amount of medical assistance paid to or on behalf of the person as a result of the injury must be deducted next, and paid to the state agency. The rest must be paid to the medical assistance recipient or other plaintiff. The plaintiff, however, must receive at least one-third of the net recovery after attorney fees and other collection costs.

History: *1975 c 247 s 6; 1976 c 236 s 2; 1986 c 444; 1Sp1986 c 3 art 1 s 82; 1987 c 370 art 2 s 5-8; 1988 c 689 art 2 s 143; 1Sp1993 c 1 art 5 s 29; 1995 c 207 art 6 s 26; 1997 c 217 art 2 s 5-7; 1999 c 245 art 4 s 28-30; 2004 c 228 art 1 s 75*

NOTE: This section was preempted by federal law to the extent that it allows a lien for medical assistance paid to be placed on a medical assistance recipient's cause of action before the recipient's death. Martin ex rel. Hoff v. City of Rochester, 642 N.W.2d 1 (Minn. 2002).

256B.043 COST-CONTAINMENT EFFORTS.

Subdivision 1. **Alternative and complementary health care.** The commissioner of human services, through the medical director and in consultation with the Health Services Policy Committee established under section 256B.0625, subdivision 3c, as part of the commissioner's ongoing duties, shall consider the potential for improving quality and obtaining cost savings through greater use of alternative and complementary treatment methods and clinical practice; shall incorporate these methods into the medical assistance, MinnesotaCare, and general assistance medical care programs; and shall make related legislative recommendations as appropriate. The commissioner shall post the recommendations required under this subdivision on agency Web sites.

Subd. 2. **Access to care.** (a) The commissioners of human services and health, as part of their ongoing duties, shall consider the adequacy of the current system of community health clinics and centers both statewide and in urban areas with significant disparities in health status and access to services across racial and ethnic groups, including:

(1) methods to provide 24-hour availability of care through the clinics and centers;

(2) methods to expand the availability of care through the clinics and centers;

(3) the use of grants to expand the number of clinics and centers, the services provided, and the availability of care; and

(4) the extent to which increased use of physician assistants, nurse practitioners, medical residents and interns, and other allied health professionals in clinics and centers would increase the availability of services.

(b) The commissioners shall make departmental modifications and legislative recommendations as appropriate on the basis of their considerations under paragraph (a).

History: *2006 c 267 art 1 s 9; 2014 c 192 art 4 s 2*

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256B.05 ADMINISTRATION BY COUNTY AGENCIES.

Subdivision 1. **Administration of medical assistance.** The county agencies shall administer medical assistance in their respective counties under the supervision of the state agency and the commissioner of human services as specified in section 256.01, and shall make such reports, prepare such statistics, and keep such records and accounts in relation to medical assistance as the state agency may require under section 256.01, subdivision 2, paragraph (17).

Subd. 2. **Fee or charges.** In administering the medical assistance program, no local social services agency shall pay a fee or charge for medical, dental, surgical, hospital, nursing, licensed nursing home care, medicine, or medical supplies in excess of the schedules of maximum fees and charges as established by the state agency.

Subd. 3. **Maximum allowances.** Notwithstanding the provisions of subdivision 2, the commissioner of human services shall establish a schedule of maximum allowances to be paid by the state on behalf of recipients of medical assistance toward fees charged for services rendered such medical assistance recipients.

Subd. 4. [Repealed, 1987 c 403 art 2 s 164]

Subd. 5. **Obligation of local agency to process medical assistance applications within established timelines.** The local agency must act on an application for medical assistance within ten working days of receipt of all information needed to act on the application but no later than required under Minnesota Rules, part 9505.0090, subparts 2 and 3.

History: *Ex1967 c 16 s 5; 1971 c 961 s 28; 1982 c 640 s 4; 1984 c 580 s 3; 1984 c 654 art 5 s 58; 1988 c 719 art 8 s 13; 1989 c 89 s 10; 1994 c 631 s 31; 1Sp2011 c 9 art 7 s 5*

256B.055 ELIGIBILITY CATEGORIES.

Subdivision 1. **Children eligible for subsidized adoption assistance.** Medical assistance may be paid for a child eligible for or receiving adoption assistance payments under title IV-E of the Social Security Act, United States Code, title 42, sections 670 to 676, and to any child who is not title IV-E eligible but who was determined eligible for adoption assistance under chapter 256N or section 259A.10, subdivision 2, and has a special need for medical or rehabilitative care.

Subd. 2. **Subsidized foster children.** Medical assistance may be paid for a child eligible for or receiving foster care maintenance payments under Title IV-E of the Social Security Act, United States Code, title 42, sections 670 to 676.

Subd. 3. [Repealed, 2013 c 108 art 1 s 68]

Subd. 3a. **Families with children.** Medical assistance may be paid for a person who is a child under the age of 19; the parent or stepparent of a child under the age of 19, including a pregnant woman; or a caretaker relative of a child under the age of 19.

Subd. 4. **Recipients of Minnesota supplemental aid.** Medical assistance may be paid for a person who is receiving public assistance under the Minnesota supplemental aid program.

Subd. 5. [Repealed, 2013 c 108 art 1 s 68]

Subd. 6. **Pregnant women; needy unborn child.** Medical assistance may be paid for a pregnant woman who meets the other eligibility criteria of this section and whose unborn child would be eligible as a needy

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child under subdivision 10 if born and living with the woman. In accordance with Code of Federal Regulations, title 42, section 435.956, the commissioner must accept self-attestation of pregnancy unless the agency has information that is not reasonably compatible with such attestation. For purposes of this subdivision, a woman is considered pregnant for 60 days postpartum.

Subd. 7. **Aged, blind, or disabled persons.** (a) Medical assistance may be paid for a person who meets the categorical eligibility requirements of the Supplemental Security Income program or, who would meet those requirements except for excess income or assets, and who meets the other eligibility requirements of this section.

(b) Following a determination that the applicant is not aged or blind and does not meet any other category of eligibility for medical assistance and has not been determined disabled by the Social Security Administration, applicants under this subdivision shall be referred to the commissioner's state medical review team for a determination of disability.

Subd. 7a. **Special category for disabled children.** Medical assistance may be paid for a person who is under age 18 and who meets income and asset eligibility requirements of the Supplemental Security Income program if the person was receiving Supplemental Security Income payments on the date of enactment of section 211(a) of Public Law 104-193, the Personal Responsibility and Work Opportunity Act of 1996, and the person would have continued to receive the payments except for the change in the childhood disability criteria in section 211(a) of Public Law 104-193.

Subd. 8. [Repealed, 1990 c 568 art 3 s 104]

Subd. 9. **Children.** Medical assistance may be paid for a person who is under 21 years of age and in need of medical care that neither the person nor the person's relatives responsible under sections 256B.01 to 256B.26 are financially able to provide.

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

Subd. 10a. [Repealed, 1Sp2003 c 14 art 12 s 101]

Subd. 10b. [Repealed, 2013 c 108 art 1 s 68]

Subd. 11. **Elderly hospital inpatients.** Medical assistance may be paid for a person who is residing in a hospital for treatment of mental disease or tuberculosis and is 65 years of age or older and without means sufficient to pay the per capita hospital charge.

Subd. 12. **Disabled children.** (a) A person is eligible for medical assistance if the person is under age 19 and qualifies as a disabled individual under United States Code, title 42, section 1382c(a), and would be eligible for medical assistance under the state plan if residing in a medical institution, and the child requires a level of care provided in a hospital, nursing facility, or intermediate care facility for persons with developmental disabilities, for whom home care is appropriate, provided that the cost to medical assistance under this section is not more than the amount that medical assistance would pay for if the child resides in an institution. After the child is determined to be eligible under this section, the commissioner shall review the child's disability under United States Code, title 42, section 1382c(a) and level of care defined

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under this section no more often than annually and may elect, based on the recommendation of health care professionals under contract with the state medical review team, to extend the review of disability and level of care up to a maximum of four years. The commissioner's decision on the frequency of continuing review of disability and level of care is not subject to administrative appeal under section 256.045. The county agency shall send a notice of disability review to the enrollee six months prior to the date the recertification of disability is due. Nothing in this subdivision shall be construed as affecting other redeterminations of medical assistance eligibility under this chapter and annual cost-effective reviews under this section.

(b) For purposes of this subdivision, "hospital" means an institution as defined in section 144.696, subdivision 3, 144.55, subdivision 3, or Minnesota Rules, part 4640.3600, and licensed pursuant to sections 144.50 to 144.58. For purposes of this subdivision, a child requires a level of care provided in a hospital if the child is determined by the commissioner to need an extensive array of health services, including mental health services, for an undetermined period of time, whose health condition requires frequent monitoring and treatment by a health care professional or by a person supervised by a health care professional, who would reside in a hospital or require frequent hospitalization if these services were not provided, and the daily care needs are more complex than a nursing facility level of care.

A child with serious emotional disturbance requires a level of care provided in a hospital if the commissioner determines that the individual requires 24-hour supervision because the person exhibits recurrent or frequent suicidal or homicidal ideation or behavior, recurrent or frequent psychosomatic disorders or somatopsychic disorders that may become life threatening, recurrent or frequent severe socially unacceptable behavior associated with psychiatric disorder, ongoing and chronic psychosis or severe, ongoing and chronic developmental problems requiring continuous skilled observation, or severe disabling symptoms for which office-centered outpatient treatment is not adequate, and which overall severely impact the individual's ability to function.

(c) For purposes of this subdivision, "nursing facility" means a facility which provides nursing care as defined in section 144A.01, subdivision 5, licensed pursuant to sections 144A.02 to 144A.10, which is appropriate if a person is in active restorative treatment; is in need of special treatments provided or supervised by a licensed nurse; or has unpredictable episodes of active disease processes requiring immediate judgment by a licensed nurse. For purposes of this subdivision, a child requires the level of care provided in a nursing facility if the child is determined by the commissioner to meet the requirements of the preadmission screening assessment document under section 256B.0911, adjusted to address age-appropriate standards for children age 18 and under.

(d) For purposes of this subdivision, "intermediate care facility for persons with developmental disabilities" or "ICF/DD" means a program licensed to provide services to persons with developmental disabilities under section 252.28, and chapter 245A, and a physical plant licensed as a supervised living facility under chapter 144, which together are certified by the Minnesota Department of Health as meeting the standards in Code of Federal Regulations, title 42, part 483, for an intermediate care facility which provides services for persons with developmental disabilities who require 24-hour supervision and active treatment for medical, behavioral, or habilitation needs. For purposes of this subdivision, a child requires a level of care provided in an ICF/DD if the commissioner finds that the child has a developmental disability in accordance with section 256B.092, is in need of a 24-hour plan of care and active treatment similar to persons with developmental disabilities, and there is a reasonable indication that the child will need ICF/DD services.

(e) For purposes of this subdivision, a person requires the level of care provided in a nursing facility if the person requires 24-hour monitoring or supervision and a plan of mental health treatment because of specific symptoms or functional impairments associated with a serious mental illness or disorder diagnosis, which

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meet severity criteria for mental health established by the commissioner and published in March 1997 as the Minnesota Mental Health Level of Care for Children and Adolescents with Severe Emotional Disorders.

(f) The determination of the level of care needed by the child shall be made by the commissioner based on information supplied to the commissioner by the parent or guardian, the child's physician or physicians, and other professionals as requested by the commissioner. The commissioner shall establish a screening team to conduct the level of care determinations according to this subdivision.

(g) If a child meets the conditions in paragraph (b), (c), (d), or (e), the commissioner must assess the case to determine whether:

(1) the child qualifies as a disabled individual under United States Code, title 42, section 1382c(a), and would be eligible for medical assistance if residing in a medical institution; and

(2) the cost of medical assistance services for the child, if eligible under this subdivision, would not be more than the cost to medical assistance if the child resides in a medical institution to be determined as follows:

(i) for a child who requires a level of care provided in an ICF/DD, the cost of care for the child in an institution shall be determined using the average payment rate established for the regional treatment centers that are certified as ICF's/DD;

(ii) for a child who requires a level of care provided in an inpatient hospital setting according to paragraph (b), cost-effectiveness shall be determined according to Minnesota Rules, part 9505.3520, items F and G; and

(iii) for a child who requires a level of care provided in a nursing facility according to paragraph (c) or (e), cost-effectiveness shall be determined according to Minnesota Rules, part 9505.3040, except that the nursing facility average rate shall be adjusted to reflect rates which would be paid for children under age 16. The commissioner may authorize an amount up to the amount medical assistance would pay for a child referred to the commissioner by the preadmission screening team under section 256B.0911.

Subd. 13. **Residents of institutions for mental diseases.** Beginning October 1, 2003, persons who would be eligible for medical assistance under this chapter but for residing in a facility that is determined by the commissioner or the federal Centers for Medicare and Medicaid Services to be an institution for mental diseases are eligible for medical assistance without federal financial participation, except that coverage shall not include payment for a nursing facility determined to be an institution for mental diseases.

Subd. 14. **Persons detained by law.** (a) Medical assistance may be paid for an inmate of a correctional facility who is conditionally released as authorized under section 241.26, 244.065, or 631.425, if the individual does not require the security of a public detention facility and is housed in a halfway house or community correction center, or under house arrest and monitored by electronic surveillance in a residence approved by the commissioner of corrections, and if the individual meets the other eligibility requirements of this chapter.

(b) An individual who is enrolled in medical assistance, and who is charged with a crime and incarcerated for less than 12 months shall be suspended from eligibility at the time of incarceration until the individual is released. Upon release, medical assistance eligibility is reinstated without reapplication using a reinstatement process and form, if the individual is otherwise eligible.

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(c) An individual, regardless of age, who is considered an inmate of a public institution as defined in Code of Federal Regulations, title 42, section 435.1010, and who meets the eligibility requirements in section 256B.056, is not eligible for medical assistance, except for covered services received while an inpatient in a medical institution as defined in Code of Federal Regulations, title 42, section 435.1010. Security issues, including costs, related to the inpatient treatment of an inmate are the responsibility of the entity with jurisdiction over the inmate.

Subd. 15. **Adults without children.** Medical assistance may be paid for a person who is:

(1) at least age 21 and under age 65;

(2) not pregnant;

(3) not entitled to Medicare Part A or enrolled in Medicare Part B under Title XVIII of the Social Security Act;

(4) not otherwise eligible under subdivision 7 as a person who meets the categorical eligibility requirements of the Supplemental Security Income program;

(5) not enrolled under subdivision 7 as a person who would meet the categorical eligibility requirements of the Supplemental Security Income program except for excess income or assets; and

(6) not described in another subdivision of this section.

Subd. 16. **Children ages 19 and 20.** Medical assistance may be paid for children who are 19 to 20 years of age.

Subd. 17. **Adults who were in foster care at the age of 18.** Medical assistance may be paid for a person under 26 years of age who was in foster care under the commissioner's responsibility on the date of attaining 18 years of age, and who was enrolled in medical assistance under the state plan or a waiver of the plan while in foster care, in accordance with section 2004 of the Affordable Care Act.

History: *Ex1967 c 16 s 6; 1969 c 841 s 1; 1973 c 717 s 18; 1974 c 525 s 1,2; 1975 c 247 s 10; 1976 c 236 s 3; 1977 c 448 s 6; 1978 c 760 s 1; 1979 c 309 s 4; 1980 c 509 s 106; 1980 c 527 s 1; 1981 c 360 art 2 s 28; 1Sp1981 c 2 s 14; 3Sp1981 c 2 art 1 s 32; 3Sp1981 c 3 s 17; 1982 c 553 s 6; 1982 c 640 s 5; 1983 c 312 art 5 s 15; 1984 c 422 s 1; 1984 c 534 s 22; 1984 c 654 art 5 s 58; 1985 c 248 s 70; 1985 c 252 s 21; 1986 c 444; 1Sp1986 c 1 art 8 s 5; 1987 c 403 art 2 s 79,80; 1988 c 689 art 2 s 144,145,268; 1989 c 282 art 3 s 43,44; 1990 c 568 art 3 s 23-27; 1991 c 292 art 4 s 33,34; 1Sp1993 c 1 art 5 s 30; 1994 c 631 s 31; 1995 c 207 art 6 s 27; 1995 c 234 art 6 s 35; 1996 c 451 art 2 s 7; 1997 c 85 art 3 s 10-12; 1997 c 203 art 4 s 19; 1998 c 407 art 4 s 13,14; 1999 c 245 art 4 s 31; 1Sp2001 c 9 art 2 s 15; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 12 s 15; 2004 c 288 art 3 s 21; 2005 c 10 art 1 s 47; 2005 c 56 s 1; 1Sp2005 c 4 art 8 s 19; 2007 c 147 art 4 s 3; 2008 c 220 s 1; 2008 c 326 art 1 s 8; 2009 c 79 art 6 s 7; art 8 s 17; 2010 c 310 art 3 s 1; 1Sp2010 c 1 art 16 s 5,48; 2013 c 1 s 2; 2013 c 107 art 4 s 5; 2013 c 108 art 1 s 9-13; art 6 s 6; 2013 c 125 art 1 s 46,107; 2014 c 312 art 25 s 7*

256B.056 ELIGIBILITY REQUIREMENTS FOR MEDICAL ASSISTANCE.

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 Code of Federal Regulations, title 42, section 435.403.

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Subd. 1a. **Income and assets generally.** (a)(1) 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, except as provided under subdivision 3, paragraph (a), clause (6).

(2) Increases in benefits under title II of the Social Security Act shall not be counted as income for purposes of this subdivision until July 1 of each year. Effective upon federal approval, for children eligible under section 256B.055, subdivision 12, or for home and community-based waiver services whose eligibility for medical assistance is determined without regard to parental income, child support payments, including any payments made by an obligor in satisfaction of or in addition to a temporary or permanent order for child support, and Social Security payments are not counted as income.

(b)(1) The modified adjusted gross income methodology as defined in the Affordable Care Act shall be used for eligibility categories based on:

(i) children under age 19 and their parents and relative caretakers as defined in section 256B.055, subdivision 3a;

(ii) children ages 19 to 20 as defined in section 256B.055, subdivision 16;

(iii) pregnant women as defined in section 256B.055, subdivision 6;

(iv) infants as defined in sections 256B.055, subdivision 10, and 256B.057, subdivision 8; and

(v) adults without children as defined in section 256B.055, subdivision 15.

For these purposes, a "methodology" does not include an asset or income standard, or accounting method, or method of determining effective dates.

(2) For individuals whose income eligibility is determined using the modified adjusted gross income methodology in clause (1), the commissioner shall subtract from the individual's modified adjusted gross income an amount equivalent to five percent of the federal poverty guidelines.

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

Subd. 1c. **Families with children income methodology.** (a) The commissioner shall adjust the income standards under this section each July 1 by the annual update of the federal poverty guidelines following publication by the United States Department of Health and Human Services except that the income standards shall not go below those in effect on July 1, 2009.

(b) For children age 18 or under, annual gifts of $2,000 or less by a tax-exempt organization to or for the benefit of the child with a life-threatening illness must be disregarded from income.

Subd. 1d. **Treatment of certain monetary gifts.** The commissioner shall disregard as income any portion of a monetary gift received by an applicant or enrollee that is designated to purchase a prosthetic device not covered by insurance, other third-party payers, or medical assistance.

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Subd. 2. **Homestead exclusion for persons residing in a long-term care facility.** 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:

(1) the spouse;

(2) a child under age 21;

(3) a child of any age who is blind or permanently and totally disabled as defined in the Supplemental Security Income program;

(4) 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

(5) a child of any age or 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. 2a. **Home equity limit for medical assistance payment of long-term care services.** (a) Effective for requests of medical assistance payment of long-term care services filed on or after July 1, 2006, and for renewals on or after July 1, 2006, for persons who received payment of long-term care services under a request filed on or after January 1, 2006, the equity interest in the home of a person whose eligibility for long-term care services is determined on or after January 1, 2006, shall not exceed $500,000, unless it is the lawful residence of the person's spouse or child who is under age 21, or a child of any age who is blind or permanently and totally disabled as defined in the Supplemental Security Income program. The amount specified in this paragraph shall be increased beginning in year 2011, from year to year based on the percentage increase in the Consumer Price Index for all urban consumers (all items; United States city average), rounded to the nearest $1,000.

(b) For purposes of this subdivision, a "home" means any real or personal property interest, including an interest in an agricultural homestead as defined under section 273.124, subdivision 1, that, at the time of the request for medical assistance payment of long-term care services, is the primary dwelling of the person or was the primary dwelling of the person before receipt of long-term care services began outside of the home.

(c) A person denied or terminated from medical assistance payment of long-term care services because the person's home equity exceeds the home equity limit may seek a waiver based upon a hardship by filing a written request with the county agency. Hardship is an imminent threat to the person's health and well-being that is demonstrated by documentation of no alternatives for payment of long-term care services. The county agency shall make a decision regarding the written request to waive the home equity limit within 30 days if all necessary information has been provided. The county agency shall send the person and the person's representative a written notice of decision on the request for a demonstrated hardship waiver that also advises the person of appeal rights under the fair hearing process of section 256.045.

Subd. 3. **Asset limitations for certain individuals.** (a) 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

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

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

(2) 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;

(3) motor vehicles are excluded to the same extent excluded by the Supplemental Security Income program;

(4) assets designated as burial expenses are excluded to the same extent excluded by the Supplemental Security Income program. Burial expenses funded by annuity contracts or life insurance policies must irrevocably designate the individual's estate as contingent beneficiary to the extent proceeds are not used for payment of selected burial expenses;

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

(6) when a person enrolled in medical assistance under section 256B.057, subdivision 9, is age 65 or older and has been enrolled during each of the 24 consecutive months before the person's 65th birthday, the assets owned by the person and the person's spouse must be disregarded, up to the limits of section 256B.057, subdivision 9, paragraph (d), when determining eligibility for medical assistance under section 256B.055, subdivision 7. The income of a spouse of a person enrolled in medical assistance under section 256B.057, subdivision 9, during each of the 24 consecutive months before the person's 65th birthday must be disregarded when determining eligibility for medical assistance under section 256B.055, subdivision 7. Persons eligible under this clause are not subject to the provisions in section 256B.059; and

(7) effective July 1, 2009, certain assets owned by American Indians are excluded as required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. For purposes of this clause, an American Indian is any person who meets the definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

(b) No asset limit shall apply to persons eligible under section 256B.055, subdivision 15.

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

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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 a developmental disability living in an intermediate care facility for persons with developmental disabilities; 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) Except as provided in paragraphs (c) and (d), trusts established after August 10, 1993, are treated according to section 13611(b) of the Omnibus Budget Reconciliation Act of 1993 (OBRA), Public Law 103-66.

(c) For purposes of paragraph (d), a pooled trust means a trust established under United States Code, title 42, section 1396p(d)(4)(C).

(d) A beneficiary's interest in a pooled trust is considered an available asset unless the trust provides that upon the death of the beneficiary or termination of the trust during the beneficiary's lifetime, whichever is sooner, the department receives any amount, up to the amount of medical assistance benefits paid on behalf of the beneficiary, remaining in the beneficiary's trust account after a deduction for reasonable administrative fees and expenses, and an additional remainder amount. The retained remainder amount of the subaccount must not exceed ten percent of the account value at the time of the beneficiary's death or termination of the trust, and must only be used for the benefit of disabled individuals who have a beneficiary interest in the pooled trust.

[See Note.]

Subd. 3c. **Asset limitations for families and children.** (a) A household of two or more persons must not own more than $20,000 in total net assets, and a household of one person must not own more than $10,000 in total net assets. In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. The value of assets that are not considered in determining eligibility for medical assistance for families and children is the value of those assets excluded under the AFDC state plan as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law 104-193, with the following exceptions:

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

(2) capital and operating assets of a trade or business up to $200,000 are not considered, except that a bank account that contains personal income or assets, or is used to pay personal expenses, is not considered a capital or operating asset of a trade or business;

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

(4) assets designated as burial expenses are excluded to the same extent they are excluded by the Supplemental Security Income program;

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

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

(7) assets owned by children are not considered; and

(8) effective July 1, 2009, certain assets owned by American Indians are excluded as required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. For purposes of this clause, an American Indian is any person who meets the definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

The assets specified in clause (2) must be disclosed to the local agency at the time of application and at the time of an eligibility redetermination, and must be verified upon request of the local agency.

(b) Beginning January 1, 2014, this subdivision applies only to parents and caretaker relatives who qualify for medical assistance under subdivision 5.

[See Note.]

Subd. 3d. **Reduction of excess assets.** Assets in excess of the limits in subdivisions 3 to 3c may be reduced to allowable limits as follows:

(a) Assets may be reduced in any of the three calendar months before the month of application in which the applicant seeks coverage by paying bills for health services that are incurred in the retroactive period for which the applicant seeks eligibility, starting with the oldest bill. After assets are reduced to allowable limits, eligibility begins with the next dollar of MA-covered health services incurred in the retroactive period. Applicants reducing assets under this subdivision who also have excess income shall first spend excess assets to pay health service bills and may meet the income spenddown on remaining bills.

(b) Assets may be reduced beginning the month of application by paying bills for health services that are incurred during the period specified in Minnesota Rules, part 9505.0090, subpart 2, that would otherwise be paid by medical assistance. After assets are reduced to allowable limits, eligibility begins with the next dollar of medical assistance covered health services incurred in the period. Applicants reducing assets under this subdivision who also have excess income shall first spend excess assets to pay health service bills and may meet the income spenddown on remaining bills.

[See Note.]

Subd. 3e. **Continuing care retirement and life care community entrance fees.** An entrance fee paid by an individual to a continuing care retirement or life care community shall be treated as an available asset to the extent that:

(1) the individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the individual be insufficient to pay for care;

(2) the individual is eligible for a refund of any remaining entrance fees when the individual dies or terminates the continuing care retirement or life care community contract and leaves the community; and

(3) the entrance fee does not confer an ownership interest in the continuing care retirement or life care community.

Subd. 4. **Income.** (a) To be eligible for medical assistance, a person eligible under section 256B.055, subdivisions 7, 7a, and 12, may have income up to 100 percent of the federal poverty guidelines. Effective

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January 1, 2000, and each successive January, recipients of Supplemental Security Income may have an income up to the Supplemental Security Income standard in effect on that date.

(b) Effective January 1, 2014, to be eligible for medical assistance, under section 256B.055, subdivision 3a, a parent or caretaker relative may have an income up to 133 percent of the federal poverty guidelines for the household size.

(c) To be eligible for medical assistance under section 256B.055, subdivision 15, a person may have an income up to 133 percent of federal poverty guidelines for the household size.

(d) To be eligible for medical assistance under section 256B.055, subdivision 16, a child age 19 to 20 may have an income up to 133 percent of the federal poverty guidelines for the household size.

(e) To be eligible for medical assistance under section 256B.055, subdivision 3a, a child under age 19 may have income up to 275 percent of the federal poverty guidelines for the household size or an equivalent standard when converted using modified adjusted gross income methodology as required under the Affordable Care Act. Children who are enrolled in medical assistance as of December 31, 2013, and are determined ineligible for medical assistance because of the elimination of income disregards under modified adjusted gross income methodology as defined in subdivision 1a remain eligible for medical assistance under the Children's Health Insurance Program Reauthorization Act of 2009, Public Law 111-3, until the date of their next regularly scheduled eligibility redetermination as required in subdivision 7a.

(f) In computing income to determine eligibility of persons under paragraphs (a) to (e) who are not residents of long-term care facilities, the commissioner shall disregard increases in income as required by Public Laws 94-566, section 503; 99-272; and 99-509. For persons eligible under paragraph (a), veteran 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, an individual is not required to make a good faith effort to sell a life estate that is not excluded under subdivision 2 and the life estate shall be deemed 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. This subdivision applies only for the purpose of determining eligibility for medical assistance, and does not apply to the valuation of assets owned by either the institutional spouse or the community spouse under section 256B.059, subdivision 2.

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

Subd. 5. **Excess income.** A person who has excess income is eligible for medical assistance if the person has expenses for medical care that are more than the amount of the person's excess income, computed by deducting incurred medical expenses from the excess income to reduce the excess to the income standard specified in subdivision 5c. The person shall elect to have the medical expenses deducted at the beginning of a one-month budget period or at the beginning of a six-month budget period. The commissioner shall allow persons eligible for assistance on a one-month spenddown basis under this subdivision to elect to pay the monthly spenddown amount in advance of the month of eligibility to the state agency in order to maintain eligibility on a continuous basis. If the recipient does not pay the spenddown amount on or before the 20th of the month, the recipient is ineligible for this option for the following month. The local agency

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shall code the Medicaid Management Information System (MMIS) to indicate that the recipient has elected this option. The state agency shall convey recipient eligibility information relative to the collection of the spenddown to providers through the Electronic Verification System (EVS). A recipient electing advance payment must pay the state agency the monthly spenddown amount on or before the 20th of the month in order to be eligible for this option in the following month.

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

Subd. 5b. [Repealed, 2013 c 108 art 1 s 68]

Subd. 5c. **Excess income standard.** (a) The excess income standard for parents and caretaker relatives, pregnant women, infants, and children ages two through 20 is the standard specified in subdivision 4, paragraph (b).

(b) The excess income standard for a person whose eligibility is based on blindness, disability, or age of 65 or more years shall equal 75 percent of the federal poverty guidelines.

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 legal representative from any third party liable for the costs of medical care. By accepting or receiving assistance, the person is deemed to have assigned the person's rights to medical support and third-party payments as required by title 19 of the Social Security Act. Persons must cooperate with the state in establishing paternity and obtaining third-party payments. By accepting 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. For the purposes of this section, "the Department of Human Services or the state" includes prepaid health plans under contract with the commissioner according to sections 256B.69, 256D.03, subdivision 4, paragraph (c), 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 the county-based purchasing entities under section 256B.692.

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. 7a. **Periodic renewal of eligibility.** (a) The commissioner shall make an annual redetermination of eligibility based on information contained in the enrollee's case file and other information available to the agency, including but not limited to information accessed through an electronic database, without requiring the enrollee to submit any information when sufficient data is available for the agency to renew eligibility.

(b) If the commissioner cannot renew eligibility in accordance with paragraph (a), the commissioner must provide the enrollee with a prepopulated renewal form containing eligibility information available to the agency and permit the enrollee to submit the form with any corrections or additional information to

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the agency and sign the renewal form via any of the modes of submission specified in section 256B.04, subdivision 18.

(c) An enrollee who is terminated for failure to complete the renewal process may subsequently submit the renewal form and required information within four months after the date of termination and have coverage reinstated without a lapse, if otherwise eligible under this chapter.

(d) Notwithstanding paragraph (a), individuals eligible under subdivision 5 shall be required to renew eligibility every six 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.

Subd. 9. **Notice.** The state agency must be given notice of monetary claims against a person, entity, or corporation that may be liable to pay all or part of the cost of medical care when the state agency has paid or becomes liable for the cost of that care. Notice must be given according to paragraphs (a) to (d).

(a) An applicant for medical assistance shall notify the state or local agency of any possible claims when the applicant submits the application. A recipient of medical assistance shall notify the state or local agency of any possible claims when those claims arise.

(b) A person providing medical care services to a recipient of medical assistance shall notify the state agency when the person has reason to believe that a third party may be liable for payment of the cost of medical care.

(c) A party to a claim that may be assigned to the state agency under this section shall notify the state agency of its potential assignment claim in writing at each of the following stages of a claim:

(1) when a claim is filed;

(2) when an action is commenced; and

(3) when a claim is concluded by payment, award, judgment, settlement, or otherwise.

(d) Every party involved in any stage of a claim under this subdivision is required to provide notice to the state agency at that stage of the claim. However, when one of the parties to the claim provides notice at that stage, every other party to the claim is deemed to have provided the required notice for that stage of the claim. If the required notice under this paragraph is not provided to the state agency, all parties to the claim are deemed to have failed to provide the required notice. A party to the claim includes the injured person

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or the person's legal representative, the plaintiff, the defendants, or persons alleged to be responsible for compensating the injured person or plaintiff, and any other party to the cause of action or claim, regardless of whether the party knows the state agency has a potential or actual assignment claim.

Subd. 10. **Eligibility verification.** (a) The commissioner shall require women who are applying for the continuation of medical assistance coverage following the end of the 60-day postpartum period to update their income and asset information and to submit any required income or asset verification.

(b) The commissioner shall determine the eligibility of private-sector health care coverage for infants less than one year of age eligible under section 256B.055, subdivision 10, or 256B.057, subdivision 1, paragraph (b), and shall pay for private-sector coverage if this is determined to be cost-effective.

(c) The commissioner shall verify assets and income for all applicants, and for all recipients upon renewal.

(d) The commissioner shall utilize information obtained through the electronic service established by the secretary of the United States Department of Health and Human Services and other available electronic data sources in Code of Federal Regulations, title 42, sections 435.940 to 435.956, to verify eligibility requirements. The commissioner shall establish standards to define when information obtained electronically is reasonably compatible with information provided by applicants and enrollees, including use of self-attestation, to accomplish real-time eligibility determinations and maintain program integrity.

Subd. 11. **Treatment of annuities.** (a) Any person requesting medical assistance payment of long-term care services shall provide a complete description of any interest either the person or the person's spouse has in annuities on a form designated by the department. The form shall include a statement that the state becomes a preferred remainder beneficiary of annuities or similar financial instruments by virtue of the receipt of medical assistance payment of long-term care services. The person and the person's spouse shall furnish the agency responsible for determining eligibility with complete current copies of their annuities and related documents and complete the form designating the state as the preferred remainder beneficiary for each annuity in which the person or the person's spouse has an interest.

(b) The department shall provide notice to the issuer of the department's right under this section as a preferred remainder beneficiary under the annuity or similar financial instrument for medical assistance furnished to the person or the person's spouse, and provide notice of the issuer's responsibilities as provided in paragraph (c).

(c) An issuer of an annuity or similar financial instrument who receives notice of the state's right to be named a preferred remainder beneficiary as described in paragraph (b) shall provide confirmation to the requesting agency that the state has been made a preferred remainder beneficiary. The issuer shall also notify the county agency when a change in the amount of income or principal being withdrawn from the annuity or other similar financial instrument or a change in the state's preferred remainder beneficiary designation under the annuity or other similar financial instrument occurs. The county agency shall provide the issuer with the name, address, and telephone number of a unit within the department that the issuer can contact to comply with this paragraph.

(d) "Preferred remainder beneficiary" for purposes of this subdivision and sections 256B.0594 and 256B.0595 means the state is a remainder beneficiary in the first position in an amount equal to the amount of medical assistance paid on behalf of the institutionalized person, or is a remainder beneficiary in the second position if the institutionalized person designates and is survived by a remainder beneficiary who is (1) a spouse who does not reside in a medical institution, (2) a minor child, or (3) a child of any age

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who is blind or permanently and totally disabled as defined in the Supplemental Security Income program. Notwithstanding this paragraph, the state is the remainder beneficiary in the first position if the spouse or child disposes of the remainder for less than fair market value.

(e) For purposes of this subdivision, "institutionalized person" and "long-term care services" have the meanings given in section 256B.0595, subdivision 1, paragraph (g).

(f) For purposes of this subdivision, "medical institution" means a skilled nursing facility, intermediate care facility, intermediate care facility for persons with developmental disabilities, nursing facility, or inpatient hospital.

History: *Ex1967 c 16 s 6; 1969 c 841 s 1; 1973 c 717 s 18; 1974 c 525 s 1,2; 1975 c 247 s 10; 1976 c 236 s 3; 1977 c 448 s 6; 1978 c 760 s 1; 1979 c 309 s 4; 1980 c 509 s 106; 1980 c 527 s 1; 1981 c 360 art 2 s 28; 1Sp1981 c 2 s 14; 3Sp1981 c 2 art 1 s 32; 3Sp1981 c 3 s 17; 1982 c 553 s 6; 1982 c 640 s 5; 1983 c 312 art 5 s 15; 1984 c 422 s 1; 1984 c 534 s 22; 1984 c 654 art 5 s 58; 1985 c 248 s 70; 1985 c 252 s 21; 1986 c 444; 1Sp1986 c 1 art 8 s 5; 1987 c 403 art 2 s 79,80; 1988 c 689 art 2 s 144,145,268; 1989 c 282 art 3 s 45-47; 1989 c 332 s 1; 1990 c 568 art 3 s 28-32; 1992 c 513 art 7 s 34-38; 1993 c 339 s 13; 1Sp1993 c 1 art 5 s 31; art 6 s 25; 1995 c 207 art 6 s 28,29; 1995 c 248 art 17 s 1-4; 1996 c 451 art 2 s 8,9; 1997 c 85 art 3 s 13-15; 1997 c 203 art 4 s 20,21; 1997 c 225 art 6 s 4; 1998 c 407 art 4 s 15,16; 1999 c 245 art 4 s 32; art 10 s 10; 2001 c 203 s 5,6; 1Sp2001 c 9 art 2 s 16-24; 2002 c 220 art 15 s 6; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 2 s 16; art 12 s 16-18; 2004 c 228 art 1 s 75; 2005 c 56 s 1; 2005 c 98 art 2 s 2; 1Sp2005 c 4 art 8 s 20-26; 2006 c 282 art 17 s 25-27; 2007 c 147 art 4 s 4; art 5 s 8; 2008 c 326 art 1 s 9-12; 2009 c 79 art 5 s 17,18; 2009 c 173 art 1 s 17; art 3 s 6-8; 2010 c 310 art 16 s 1; 1Sp2010 c 1 art 16 s 6,7,48; art 24 s 9,10,13; 1Sp2011 c 9 at 6 s 84,85,88; art 7 s 6; 2012 c 216 art 13 s 3,4; 2012 c 247 art 4 s 15,16; 2013 c 1 s 3-5; 2013 c 63 s 5; 2013 c 107 art 4 s 6; 2013 c 108 art 1 s 14-20*

NOTE: The amendment to subdivision 3b by Laws 2009, chapter 173, article 1, section 17, is effective for pooled trust accounts established on or after January 1, 2014, or upon the date it is no longer subject to the maintenance of effort requirement in Public Law 111-148. The commissioner of human services shall notify the revisor of statutes of that date. Laws 2009, chapter 173, article 1, section 17, the effective date, as amended by Laws 2010, First Special Session chapter 1, article 24, section 13; and Laws 2011, First Special Session chapter 9, article 6, section 88.

NOTE: The amendment to subdivision 3c by Laws 2009, chapter 79, article 5, section 17, is effective October 1, 2019, or the date it is no longer subject to the maintenance of effort requirement in Public Law 111-148. The commissioner of human services shall notify the revisor of statutes of that date. Laws 2009, chapter 79, article 5, section 17, the effective date, as amended by Laws 2010, First Special Session chapter 1, article 24, section 9; and Laws 2011, First Special Session chapter 9, article 6, section 84.

NOTE: The amendment to subdivision 3d by Laws 2009, chapter 79, article 5, section 18, is effective January 1, 2014, or upon the date it is no longer subject to the maintenance of effort requirement in Public Law 111-148. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2009, chapter 79, article 5, section 18, the effective date, as amended by Laws 2010, First Special Session chapter 1, article 24, section 10; and Laws 2011, First Special Session chapter 9, article 6, section 85.

256B.057 ELIGIBILITY REQUIREMENTS FOR SPECIAL CATEGORIES.

Subdivision 1. **Infants and pregnant women.** (a) An infant less than two years of age or a pregnant woman is eligible for medical assistance if the individual's countable household income is equal to or less

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than 275 percent of the federal poverty guideline for the same household size or an equivalent standard when converted using modified adjusted gross income methodology as required under the Affordable Care Act.

(b) An infant born to a woman who was eligible for and receiving medical assistance on the date of the child's birth shall continue to be eligible for medical assistance without redetermination until the child's first birthday.

Subd. 1a. [Repealed, 1998 c 407 art 5 s 48]

Subd. 1b. [Repealed, 1Sp2003 c 14 art 12 s 101]

Subd. 1c. [Repealed, 2013 c 108 art 1 s 68]

Subd. 2. [Repealed, 2013 c 108 art 1 s 68]

Subd. 2a. [Repealed, 1997 c 203 art 4 s 73]

Subd. 2b. [Repealed, 1997 c 203 art 4 s 73]

Subd. 2c. [Repealed, 1Sp2011 c 9 art 6 s 97]

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

Subd. 3a. **Eligibility for payment of Medicare Part B premiums.** A person who would otherwise be eligible as a qualified Medicare beneficiary under subdivision 3, except the person's income is in excess of the limit, is eligible for medical assistance reimbursement of Medicare Part B premiums if the person's income is less than 120 percent of the official federal poverty guidelines for the applicable family size.

Subd. 3b. **Qualifying individuals.** Beginning July 1, 1998, contingent upon federal funding, a person who would otherwise be eligible as a qualified Medicare beneficiary under subdivision 3, except that the person's income is in excess of the limit, is eligible as a qualifying individual.

If the person's income is greater than 120 percent, but less than 135 percent of the official federal poverty guidelines for the applicable family size, the person is eligible for medical assistance reimbursement of Medicare Part B premiums.

The commissioner shall limit enrollment of qualifying individuals under this subdivision according to the requirements of Public Law 105-33, section 4732.

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

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is not otherwise eligible for medical assistance, is eligible for medical assistance reimbursement of the Medicare Part A premium.

Subd. 5. **Disabled adult children.** A person who is at least 18 years old, who was eligible for Supplemental Security Income benefits on the basis of blindness or disability, who became disabled or blind before reaching the age of 22, and who lost eligibility as a result of becoming entitled to a child's insurance benefits on or after July 1, 1987, under section 202(d) of the Social Security Act, or because of an increase in those benefits effective on or after July 1, 1987, is eligible for medical assistance as long as the person would be entitled to Supplemental Security Income in the absence of child's insurance benefits or increases in those benefits.

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

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

Subd. 8. **Children under age two.** Medical assistance may be paid for a child under two years of age whose countable household income is above 275 percent of the federal poverty guidelines for the same household size but less than or equal to 280 percent of the federal poverty guidelines for the same household size or an equivalent standard when converted using modified adjusted gross income methodology as required under the Affordable Care Act.

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

(1) but for excess earnings or assets, meets the definition of disabled under the Supplemental Security Income program;

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

(3) pays a premium and other obligations under paragraph (e).

(b) For purposes of eligibility, there is a $65 earned income disregard. To be eligible for medical assistance under this subdivision, a person must have more than $65 of earned income. Earned income must have Medicare, Social Security, and applicable state and federal taxes withheld. The person must document earned income tax withholding. Any spousal income or assets shall be disregarded for purposes of eligibility and premium determinations.

(c) After the month of enrollment, a person enrolled in medical assistance under this subdivision who:

(1) is temporarily unable to work and without receipt of earned income due to a medical condition, as verified by a physician; or

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(2) loses employment for reasons not attributable to the enrollee, and is without receipt of earned income may retain eligibility for up to four consecutive months after the month of job loss. To receive a four-month extension, enrollees must verify the medical condition or provide notification of job loss. All other eligibility requirements must be met and the enrollee must pay all calculated premium costs for continued eligibility.

(d) 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;

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

(4) spousal assets, including spouse's share of jointly held assets.

(e) All enrollees must pay a premium to be eligible for medical assistance under this subdivision, except as provided under clause (5).

(1) An enrollee must pay the greater of a $65 premium or the premium calculated based on the person's gross earned and unearned income and the applicable family size using a sliding fee scale established by the commissioner, which begins at one percent of income at 100 percent of the federal poverty guidelines and increases to 7.5 percent of income for those with incomes at or above 300 percent of the federal poverty guidelines.

(2) Annual adjustments in the premium schedule based upon changes in the federal poverty guidelines shall be effective for premiums due in July of each year.

(3) All enrollees who receive unearned income must pay five percent of unearned income in addition to the premium amount, except as provided under clause (5).

(4) Increases in benefits under title II of the Social Security Act shall not be counted as income for purposes of this subdivision until July 1 of each year.

(5) Effective July 1, 2009, American Indians are exempt from paying premiums as required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. For purposes of this clause, an American Indian is any person who meets the definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

(f) 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.

(g) Any required premium shall be determined at application and redetermined at the enrollee's six-month income review or when a change in income or household size is reported. Enrollees must report any change in income or household size within ten days of when the change occurs. A decreased premium resulting from a reported change in income or household size shall be effective the first day of the next available billing month after the change is reported. Except for changes occurring from annual cost-of-living increases, a change resulting in an increased premium shall not affect the premium amount until the next six-month review.

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(h) 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.

(i) 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. Except when an installment agreement is accepted by the commissioner, all persons disenrolled for nonpayment of a premium must pay any past due premiums as well as current premiums due prior to being reenrolled. 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.

(j) For enrollees whose income does not exceed 200 percent of the federal poverty guidelines and who are also enrolled in Medicare, the commissioner shall reimburse the enrollee for Medicare part B premiums under section 256B.0625, subdivision 15, paragraph (a).

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

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

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

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

(4) is under age 65;

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

(6) is not otherwise covered under creditable coverage, as defined under United States Code, title 42, section 1396a(aa).

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

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

Subd. 11. MS 2009 Supp [Expired, 2009 c 79 art 5 s 19; 2009 c 173 art 1 s 18]

Subd. 12. **Presumptive eligibility determinations made by qualified hospitals.** The commissioner shall establish a process to qualify hospitals that are participating providers under the medical assistance program to determine presumptive eligibility for medical assistance for applicants who may have a basis of eligibility using the modified adjusted gross income methodology as defined in section 256B.056, subdivision 1a, paragraph (b), clause (1).

History: *1986 c 444; 1989 c 282 art 3 s 48; 1990 c 568 art 3 s 33-36; 1991 c 292 art 4 s 35-39; 1992 c 513 art 7 s 39; 1992 c 549 art 4 s 12; 1993 c 345 art 9 s 11-13; 1Sp1993 c 6 s 9; 1995 c 234 art 6 s 36,37;*

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1997 c 85 art 3 s 16-18; 1997 c 203 art 4 s 22-24; 1998 c 407 art 5 s 3-5; 1998 c 407 art 4 s 17,18; 1999 c 245 art 4 s 33,34; 2000 c 260 s 97; 2000 c 340 s 3; 2000 c 488 art 9 s 15; 1Sp2001 c 9 art 2 s 25-29; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 12 s 19-23; 1Sp2005 c 4 art 7 s 4; 2007 c 147 art 13 s 1; 2008 c 286 art 1 s 5; 2008 c 326 art 1 s 13; 2008 c 358 art 3 s 5; 2009 c 79 art 5 s 19; 2009 c 173 art 1 s 18; 2010 c 310 art 3 s 2; 1Sp2010 c 1 art 17 s 9; 1Sp2011 c 9 art 7 s 7; 2012 c 216 art 13 s 5; 2012 c 247 art 4 s 17; 2013 c 63 s 6; 2013 c 107 art 4 s 7; 2013 c 108 art 1 s 21-24; 2014 c 275 art 1 s 57; 2014 c 312 art 24 s 42

NOTE: The amendment to subdivision 9 by Laws 2011, First Special Session chapter 9, article 7, section 7, is effective January 1, 2014, for adults age 21 or older, and October 1, 2019, for children before the child's 21st birthday. Laws 2011, First Special Session chapter 9, article 7, section 7, the effective date, as amended by Laws 2014, chapter 291, article 8, section 18.

256B.0571 LONG-TERM CARE PARTNERSHIP PROGRAM.

Subdivision 1. **Definitions.** For purposes of this section, the following terms have the meanings given them.

Subd. 2. [Repealed, 2006 c 282 art 17 s 37]

Subd. 3. **Long-term care insurance.** "Long-term care insurance" means a policy described in section 62S.01.

Subd. 4. **Medical assistance.** "Medical assistance" means the program of medical assistance established under section 256B.01.

Subd. 5. [Repealed, 2006 c 282 art 17 s 37]

Subd. 6. **Partnership policy.** "Partnership policy" means a long-term care insurance policy that meets the criteria in sections 62S.23, subdivision 1, paragraph (b), and 62S.312 and was issued on or after July 1, 2006, or exchanged on or after July 1, 2006, under the provisions of section 62S.24, subdivision 8.

Subd. 7. **Partnership program.** "Partnership program" means the Minnesota partnership for long-term care program established under this section.

Subd. 7a. **Protected assets.** "Protected assets" means assets or proceeds of assets that are protected from recovery under subdivisions 13 and 15.

Subd. 8. **Program established.** (a) The commissioner, in cooperation with the commissioner of commerce, shall establish the Minnesota partnership for long-term care program to provide for the financing of long-term care through a combination of private insurance and medical assistance.

(b) An individual becomes eligible to participate in the partnership program by meeting the requirements of either clause (1) or (2):

(1) the individual may qualify as a beneficiary of a partnership policy that meets the criteria under subdivision 6. To be eligible under this clause, the individual must be a Minnesota resident at the time coverage first became effective under the partnership policy; or

(2) the individual may qualify as a beneficiary of a policy recognized under subdivision 17.

Subd. 8a. [Repealed, 2008 c 326 art 1 s 47]

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Subd. 9. **Medical assistance eligibility.** (a) Upon request for medical assistance program payment of long-term care services by an individual who meets the requirements described in subdivision 8, the commissioner shall determine the individual's eligibility for medical assistance according to paragraphs (b) to (i).

(b) After determining assets subject to the asset limit under section 256B.056, subdivision 3 or 3c, or 256B.057, subdivision 9 or 10, the commissioner shall allow the individual to designate assets to be protected from recovery under subdivisions 13 and 15 up to the dollar amount of the benefits utilized under the partnership policy as of the effective date of eligibility for medical assistance program payment of long-term care services. Benefits utilized under a long-term care insurance policy before July 1, 2006, do not count for the purpose of determining the amount of assets that can be designated. Designated assets shall be disregarded for purposes of determining eligibility for payment of long-term care services. The dollar amount of benefits utilized must be equal to the amount of claims paid by the issuer under the policy as verified by the issuer.

(c) The individual shall identify the designated assets and the full fair market value of those assets and designate them as assets to be protected at the time of application for medical assistance payment of long-term care services. The full fair market value of real property or interests in real property shall be based on the most recent full assessed value for property tax purposes for the real property, unless the individual provides a complete professional appraisal by a licensed appraiser to establish the full fair market value. The extent of a life estate in real property shall be determined using the life estate table in the health care program's manual. Ownership of any asset in joint tenancy shall be treated as ownership as tenants in common for purposes of its designation as a disregarded asset. The unprotected value of any protected asset is subject to estate recovery according to subdivisions 13 and 15.

(d) The right to designate assets to be protected is personal to the individual and ends when the individual dies, except as otherwise provided in subdivisions 13 and 15. It does not include the increase in the value of the protected asset and the income, dividends, or profits from the asset. It may be exercised by the individual or by anyone with the legal authority to do so on the individual's behalf. It shall not be sold, assigned, transferred, or given away.

(e) As the individual continues to utilize benefits under a partnership policy after eligibility for medical assistance payment of long-term care services begins, the individual may designate, for additional protection, an increase in the value of protected assets and additional assets that become available during the individual's lifetime up to the amount of additional benefits utilized. The individual must make the designation in writing no later than ten days from the date the designation is requested by the county agency. The amount used for this purpose must reduce the unused amount of asset protection available to protect assets in the individual's estate from recovery under section 256B.15 or 524.3-1202, or otherwise.

(f) This section applies only to estate recovery under United States Code, title 42, section 1396p, subsections (a) and (b), and does not apply to recovery authorized by other provisions of federal law, including, but not limited to, recovery from trusts under United States Code, title 42, section 1396p, subsection (d)(4)(A) and (C), or to recovery from annuities, or similar legal instruments, subject to section 6012, subsections (a) and (b), of the Deficit Reduction Act of 2005, Public Law 109-171.

(g) An individual's protected assets owned by the individual's spouse who applies for payment of medical assistance long-term care services shall not be protected assets or disregarded for purposes of eligibility of the individual's spouse solely because they were protected assets of the individual.

(h) Assets designated under this subdivision shall not be subject to penalty under section 256B.0595.

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(i) The commissioner shall otherwise determine the individual's eligibility for payment of long-term care services according to medical assistance eligibility requirements.

Subd. 10. [Repealed, 2010 c 310 art 4 s 5]

Subd. 11. [Repealed, 2006 c 282 art 17 s 37]

Subd. 12. **Compliance with federal law.** An issuer of a partnership policy must comply with Public Law 109-171, section 6021, including any federal regulations, as amended, adopted under that law.

Subd. 13. **Limitations on estate recovery.** (a) Protected assets of the individual shall not be subject to recovery under section 256B.15 or 524.3-1201 for medical assistance or alternative care paid on behalf of the individual. Protected assets of the individual in the estate of the individual's surviving spouse shall not be liable to pay a claim for recovery of medical assistance paid for the predeceased individual that is filed in the estate of the surviving spouse under section 256B.15. Protected assets of the individual shall not be protected assets in the surviving spouse's estate by reason of the preceding sentence and shall be subject to recovery under section 256B.15 or 524.3-1201 for medical assistance paid on behalf of the surviving spouse.

(b) The personal representative may protect the full fair market value of an individual's unprotected assets in the individual's estate in an amount equal to the unused amount of asset protection the individual had on the date of death. The personal representative shall apply the asset protection so that the full fair market value of any unprotected asset in the estate is protected. When or if the asset protection available to the personal representative is or becomes less than the full fair market value of any remaining unprotected asset, it shall be applied to partially protect one unprotected asset.

(c) The asset protection described in paragraph (a) terminates with respect to an asset includable in the individual's estate under chapter 524 or section 256B.15:

(1) when the estate distributes the asset; or

(2) if the estate of the individual has not been probated within one year from the date of death.

(d) If an individual owns a protected asset on the date of death and the estate is opened for probate more than one year after death, the state or a county agency may file and collect claims in the estate under section 256B.15, and no statute of limitations in chapter 524 that would otherwise limit or bar the claim shall apply.

(e) Except as otherwise provided, nothing in this section shall limit or prevent recovery of medical assistance.

Subd. 14. **Implementation.** (a) The commissioner, in cooperation with the commissioner of commerce, may alter the requirements of this section so as to be in compliance with forthcoming requirements of the federal Department of Health and Human Services and the National Association of Insurance Commissioners necessary to implement the long-term care partnership program requirements of Public Law 109-171, section 6021.

(b) The commissioner shall submit a state plan amendment to the federal government to implement the long-term care partnership program in accordance with this section.

Subd. 15. **Limitation on liens.** (a) An individual's interest in real property shall not be subject to a medical assistance lien under sections 514.980 to 514.985 or a lien arising under section 256B.15 while and

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to the extent it is protected under subdivision 9. An individual's interest in real property that exceeds the value protected under subdivision 9 is subject to a lien for recovery.

(b) Medical assistance liens under sections 514.980 to 514.985 or liens arising under section 256B.15 against an individual's interests in real property in the individual's estate that are designated as protected under subdivision 13, paragraph (b), shall be released to the extent of the dollar value of the protection applied to the interest.

(c) If an interest in real property is protected from a lien for recovery of medical assistance paid on behalf of the individual under paragraph (a) or (b), no lien for recovery of medical assistance paid on behalf of that individual shall be filed against the protected interest in real property after it is distributed to the individual's heirs or devisees.

Subd. 16. **Burden of proof.** Any individual or the personal representative of the individual's estate who asserts that an asset is a disregarded or protected asset under this section in connection with any determination of eligibility for benefits under the medical assistance program or any appeal, case, controversy, or other proceedings, shall have the initial burden of:

(1) documenting and proving by clear and convincing evidence that the asset or source of funds for the asset in question was designated as disregarded or protected;

(2) tracing the asset and the proceeds of the asset from that time forward; and

(3) documenting that the asset or proceeds of the asset remained disregarded or protected at all relevant times.

Subd. 17. **Reciprocal agreements.** The commissioner may enter into an agreement with any other state with a partnership program under United States Code, title 42, section 1396p(b)(1)(C), for reciprocal recognition of qualified long-term care insurance policies purchased under each state's partnership program. The commissioner shall notify the secretary of the United States Department of Health and Human Services if the commissioner declines to enter into a national reciprocal agreement.

History: *1Sp2005 c 4 art 7 s 5; 2006 c 255 s 74; 2006 c 282 art 17 s 28; 2008 c 326 art 1 s 14-18; 2008 c 363 art 17 s 7,8; 2009 c 86 art 1 s 44; 2010 c 310 art 4 s 3,4*

256B.0575 AVAILABILITY OF INCOME FOR INSTITUTIONALIZED PERSONS.

Subdivision 1. **Income deductions.** 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;

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(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, as specified in subdivision 2, incurred for necessary medical or remedial care for the institutionalized person that are recognized under state law, not medical assistance covered expenses, and 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.

Subd. 2. **Reasonable expenses.** For the purposes of subdivision 1, paragraph (a), clause (9), reasonable expenses are limited to expenses that have not been previously used as a deduction from income and were not:

(1) for long-term care expenses incurred during a period of ineligibility as defined in section 256B.0595, subdivision 2;

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(2) incurred more than three months before the month of application associated with the current period of eligibility;

(3) for expenses incurred by a recipient that are duplicative of services that are covered under chapter 256B; or

(4) nursing facility expenses incurred without a timely assessment as required under section 256B.0911.

History: *1986 c 444; 1989 c 282 art 3 s 49; 1990 c 568 art 3 s 37; 1991 c 292 art 4 s 40; 1Sp1993 c 1 art 5 s 32; 1995 c 207 art 6 s 30,125; 1996 c 451 art 2 s 10; 1999 c 245 art 4 s 35; 2002 c 277 s 10; 1Sp2005 c 4 art 8 s 27; 2009 c 79 art 5 s 20*

256B.058 TREATMENT OF INCOME OF INSTITUTIONALIZED SPOUSE.

Subdivision 1. **Income not available.** The income described in subdivisions 2 and 3 shall be deducted from an institutionalized spouse's monthly income and is not considered available for payment of the monthly costs of an institutionalized spouse after the institutionalized spouse has been determined eligible for medical assistance.

Subd. 2. **Monthly income allowance for community spouse.** (a) For an institutionalized spouse, monthly income may be allocated to the community spouse as a monthly income allowance for the community spouse. Beginning with the first full calendar month the institutionalized spouse is in the institution, the monthly income allowance is not considered available to the institutionalized spouse for monthly payment of costs of care in the institution as long as the income is made available to the community spouse.

(b) The monthly income allowance is the amount by which the community spouse's monthly maintenance needs allowance under paragraphs (c) and (d) exceeds the amount of monthly income otherwise available to the community spouse.

(c) The community spouse's monthly maintenance needs allowance is the lesser of $1,500 or 122 percent of the monthly federal poverty guideline for a family of two plus an excess shelter allowance. The excess shelter allowance is for the amount of shelter expenses that exceed 30 percent of 122 percent of the federal poverty guideline line for a family of two. Shelter expenses are the community spouse's expenses for rent, mortgage payments including principal and interest, taxes, insurance, required maintenance charges for a cooperative or condominium that is the community spouse's principal residence, and the standard utility allowance under section 5(e) of the federal Food Stamp Act of 1977. If the community spouse has a required maintenance charge for a cooperative or condominium, the standard utility allowance must be reduced by the amount of utility expenses included in the required maintenance charge.

If the community or institutionalized spouse establishes that the community spouse needs income greater than the monthly maintenance needs allowance determined in this paragraph due to exceptional circumstances resulting in significant financial duress, the monthly maintenance needs allowance may be increased to an amount that provides needed additional income.

(d) The percentage of the federal poverty guideline used to determine the monthly maintenance needs allowance in paragraph (c) is increased to 133 percent on July 1, 1991, and to 150 percent on July 1, 1992. Adjustments in the income limits due to annual changes in the federal poverty guidelines shall be implemented the first day of July following publication of the annual changes. The $1,500 maximum must be adjusted January 1, 1990, and every January 1 after that by the same percentage increase in the

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Consumer Price Index for all urban consumers (all items; United States city average) between the two previous Septembers.

(e) If a court has entered an order against an institutionalized spouse for monthly income for support of the community spouse, the community spouse's monthly income allowance under this subdivision shall not be less than the amount of the monthly income ordered.

Subd. 3. **Family allowance.** (a) A family allowance determined under paragraph (b) is not considered available to the institutionalized spouse for monthly payment of costs of care in the institution.

(b) The family allowance is equal to one-third of the amount by which 122 percent of the monthly federal poverty guideline for a family of two exceeds the monthly income for that family member.

(c) For purposes of this subdivision, the term family member only includes a minor or dependent child as defined in the Internal Revenue Code, dependent parent, or dependent sibling of the institutionalized or community spouse if the sibling resides with the community spouse.

(d) The percentage of the federal poverty guideline used to determine the family allowance in paragraph (b) is increased to 133 percent on July 1, 1991, and to 150 percent on July 1, 1992. Adjustments in the income limits due to annual changes in the federal poverty guidelines shall be implemented the first day of July following publication of the annual changes.

Subd. 4. **Treatment of income.** (a) No income of the community spouse will be considered available to an eligible institutionalized spouse, beginning the first full calendar month of institutionalization, except as provided in this subdivision.

(b) In determining the income of an institutionalized spouse or community spouse, after the institutionalized spouse has been determined eligible for medical assistance, the following rules apply.

(1) For income that is not from a trust, availability is determined according to items (i) to (v), unless the instrument providing the income otherwise specifically provides:

(i) if payment is made solely in the name of one spouse, the income is considered available only to that spouse;

(ii) if payment is made in the names of both spouses, one-half of the income is considered available to each;

(iii) if payment is made in the names of one or both spouses together with one or more other persons, the income is considered available to each spouse according to the spouse's interest, or one-half of the joint interest is considered available to each spouse if each spouse's interest is not specified;

(iv) if there is no instrument that establishes ownership, one-half of the income is considered available to each spouse; and

(v) either spouse may rebut the determination of availability of income by showing by a preponderance of the evidence that ownership interests are different than provided above.

(2) For income from a trust, income is considered available to each spouse as provided in the trust. If the trust does not specify an amount available to either or both spouses, availability will be determined according to items (i) to (iii):

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(i) if payment of income is made only to one spouse, the income is considered available only to that spouse;

(ii) if payment of income is made to both spouses, one-half is considered available to each; and

(iii) if payment is made to either or both spouses and one or more other persons, the income is considered available to each spouse in proportion to each spouse's interest, or if no such interest is specified, one-half of the joint interest is considered available to each spouse.

History: *1989 c 282 art 3 s 50; 2008 c 326 art 1 s 19*

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

Subdivision 1. **Definitions.** (a) For purposes of this section and sections 256B.058 and 256B.0595, the terms defined in this subdivision have the meanings given them.

(b) "Community spouse" means the spouse of an institutionalized spouse.

(c) "Spousal share" means one-half of the total value of all assets, to the extent that either the institutionalized spouse or the community spouse had an ownership interest at the time of the first continuous period of institutionalization.

(d) "Assets otherwise available to the community spouse" means assets individually or jointly owned by the community spouse, other than assets excluded by subdivision 5, paragraph (c).

(e) "Community spouse asset allowance" is the value of assets that can be transferred under subdivision 3.

(f) "Institutionalized spouse" means a person who is:

(1) in a hospital, nursing facility, or intermediate care facility for persons with developmental disabilities, or receiving home and community-based services under section 256B.0915, and is expected to remain in the facility or institution or receive the home and community-based services for at least 30 consecutive days; and

(2) married to a person who is not in a hospital, nursing facility, or intermediate care facility for persons with developmental disabilities, and is not receiving home and community-based services under section 256B.0915, 256B.092, or 256B.49.

(g) "For the sole benefit of" means no other individual or entity can benefit in any way from the assets or income at the time of a transfer or at any time in the future.

(h) "Continuous period of institutionalization" means a 30-consecutive-day period of time in which a person is expected to stay in a medical or long-term care facility, or receive home and community-based services that would qualify for coverage under the elderly waiver (EW) or alternative care (AC) programs. For a stay in a facility, the 30-consecutive-day period begins on the date of entry into a medical or long-term care facility. For receipt of home and community-based services, the 30-consecutive-day period begins on the date that the following conditions are met:

(1) the person is receiving services that meet the nursing facility level of care determined by a long-term care consultation;

(2) the person has received the long-term care consultation within the past 60 days;

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(3) the services are paid by the EW program under section 256B.0915 or the AC program under section 256B.0913 or would qualify for payment under the EW or AC programs if the person were otherwise eligible for either program, and but for the receipt of such services the person would have resided in a nursing facility; and

(4) the services are provided by a licensed provider qualified to provide home and community-based services.

Subd. 1a. **Institutionalized spouse.** The provisions of this section apply only when a spouse begins the first continuous period of institutionalization on or after October 1, 1989.

Subd. 2. **Assessment of spousal share.** At the beginning of the first continuous period of institutionalization of a person beginning on or after October 1, 1989, at the request of either the institutionalized spouse or the community spouse, or upon application for medical assistance, the total value of assets in which either the institutionalized spouse or the community spouse had an interest at the time of the first period of institutionalization of 30 days or more shall be assessed and documented and the spousal share shall be assessed and documented.

Subd. 3. **Community spouse asset allowance.** An institutionalized spouse may transfer assets to the community spouse for the sole benefit of the community spouse. Except for increased amounts allowable under subdivision 4, the maximum amount of assets allowed to be transferred is the amount which, when added to the assets otherwise available to the community spouse, is as follows:

(1) prior to July 1, 1994, the greater of:

(i) $14,148;

(ii) the lesser of the spousal share or $70,740; or

(iii) the amount required by court order to be paid to the community spouse; and

(2) for persons whose date of initial determination of eligibility for medical assistance following their first continuous period of institutionalization occurs on or after July 1, 1994, the greater of:

(i) $20,000;

(ii) the lesser of the spousal share or $70,740; or

(iii) the amount required by court order to be paid to the community spouse.

If the assets available to the community spouse are already at the limit permissible under this section, or the higher limit attributable to increases under subdivision 4, no assets may be transferred from the institutionalized spouse to the community spouse. The transfer must be made as soon as practicable after the date the institutionalized spouse is determined eligible for medical assistance, or within the amount of time needed for any court order required for the transfer. On January 1, 1994, and every January 1 thereafter, the limits in this subdivision shall be adjusted by the same percentage change in the Consumer Price Index for All Urban Consumers (all items; United States city average) between the two previous Septembers. These adjustments shall also be applied to the limits in subdivision 5.

Subd. 4. **Increased community spouse asset allowance; when allowed.** (a) If either the institutionalized spouse or community spouse establishes that the community spouse asset allowance under subdivision 3 (in relation to the amount of income generated by such an allowance) is not sufficient to raise the

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

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

Subd. 5. **Asset availability.** (a) At the time of initial determination of eligibility for medical assistance benefits following the first continuous period of institutionalization on or after October 1, 1989, assets considered available to the institutionalized spouse shall be the total value of all assets in which either spouse has an ownership interest, reduced by the following amount for the community spouse:

(1) prior to July 1, 1994, the greater of:

(i) $14,148;

(ii) the lesser of the spousal share or $70,740; or

(iii) the amount required by court order to be paid to the community spouse;

(2) for persons whose date of initial determination of eligibility for medical assistance following their first continuous period of institutionalization occurs on or after July 1, 1994, the greater of:

(i) $20,000;

(ii) the lesser of the spousal share or $70,740; or

(iii) the amount required by court order to be paid to the community spouse.

The value of assets transferred for the sole benefit of the community spouse under section 256B.0595, subdivision 4, in combination with other assets available to the community spouse under this section, cannot exceed the limit for the community spouse asset allowance determined under subdivision 3 or 4. Assets that exceed this allowance shall be considered available to the institutionalized spouse whether or not converted to income. If the community spouse asset allowance has been increased under subdivision 4, then the assets considered available to the institutionalized spouse under this subdivision shall be further reduced by the value of additional amounts allowed under subdivision 4.

(b) An institutionalized spouse may be found eligible for medical assistance even though assets in excess of the allowable amount are found to be available under paragraph (a) if the assets are owned jointly or individually by the community spouse, and the institutionalized spouse cannot use those assets to pay for the cost of care without the consent of the community spouse, and if: (i) the institutionalized spouse assigns to the commissioner the right to support from the community spouse under section 256B.14, subdivision 3; (ii) the institutionalized spouse lacks the ability to execute an assignment due to a physical or mental impairment; or (iii) the denial of eligibility would cause an imminent threat to the institutionalized spouse's health and well-being.

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(c) After the month in which the institutionalized spouse is determined eligible for medical assistance, during the continuous period of institutionalization, no assets of the community spouse are considered available to the institutionalized spouse, unless the institutionalized spouse has been found eligible under paragraph (b).

(d) Assets determined to be available to the institutionalized spouse under this section must be used for the health care or personal needs of the institutionalized spouse.

(e) For purposes of this section, assets do not include assets excluded under the Supplemental Security Income program.

History: *1989 c 282 art 3 s 51; 1990 c 568 art 3 s 38,39; 1991 c 199 art 1 s 61; 1992 c 513 art 7 s 40,41; 1Sp1993 c 1 art 5 s 33,34; 1995 c 207 art 6 s 31-33; 1997 c 107 s 3-6; 2002 c 220 art 15 s 7-9; 2005 c 56 s 1; 2008 c 326 art 1 s 20,21*

256B.0594 PAYMENT OF BENEFITS FROM AN ANNUITY.

When payment becomes due under an annuity that names the department a remainder beneficiary, the issuer shall request and the department shall, within 45 days after receipt of the request, provide a written statement of the total amount of the medical assistance paid or confirmation that any family member designated as a remainder beneficiary meets requirements for qualification as a beneficiary in the first position. Upon timely receipt of the written statement of the amount of medical assistance paid, the issuer shall pay the department an amount equal to the lesser of the amount due the department under the annuity or the total amount of medical assistance paid on behalf of the individual or the individual's spouse. Any amounts remaining after the issuer's payment to the department shall be payable according to the terms of the annuity or similar financial instrument. The county agency or the department shall provide the issuer with the name, address, and telephone number of a unit within the department the issuer can contact to comply with this section. The requirements of section 72A.201, subdivision 4, clause (3), shall not apply to payments made under this section until the issuer has received final payment information from the department, if the issuer has notified the beneficiary of the requirements of this section at the time it initially requests payment information from the department.

History: *2006 c 282 art 17 s 29; 2008 c 326 art 1 s 22*

256B.0595 PROHIBITIONS ON TRANSFER; EXCEPTIONS.

Subdivision 1. **Prohibited transfers.** (a) Effective for transfers made after August 10, 1993, an institutionalized person, an institutionalized person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the institutionalized person or institutionalized person's spouse, may not give away, sell, or dispose of, for less than fair market value, any asset or interest therein, except assets other than the homestead that are excluded under the Supplemental Security Income program, for the purpose of establishing or maintaining medical assistance eligibility. This applies to all transfers, including those made by a community spouse after the month in which the institutionalized spouse is determined eligible for medical assistance. For purposes of determining eligibility for long-term care services, any transfer of such assets within 36 months before or any time after an institutionalized person requests medical assistance payment of long-term care services, or 36 months before or any time after a medical assistance recipient becomes an institutionalized person, for less than fair market value may be considered. Any such transfer is presumed to have been made for the purpose of establishing or maintaining medical assistance eligibility and the institutionalized person is ineligible for long-term care services for the period of time determined under subdivision 2, unless the institutionalized

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person furnishes convincing evidence to establish that the transaction was exclusively for another purpose, or unless the transfer is permitted under subdivision 3 or 4. In the case of payments from a trust or portions of a trust that are considered transfers of assets under federal law, or in the case of any other disposal of assets made on or after February 8, 2006, any transfers made within 60 months before or any time after an institutionalized person requests medical assistance payment of long-term care services and within 60 months before or any time after a medical assistance recipient becomes an institutionalized person, may be considered.

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

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

(d) This section applies to the portion of any asset or interest that an institutionalized person, an institutionalized person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the institutionalized person or the institutionalized person's spouse, transfers to any annuity that exceeds the value of the benefit likely to be returned to the institutionalized person or institutionalized person's spouse while alive, based on estimated life expectancy as determined according to the current actuarial tables published by the Office of the Chief Actuary of the Social Security Administration. The commissioner may adopt rules reducing life expectancies based on the need for long-term care. This section applies to an annuity purchased on or after March 1, 2002, that:

(1) is not purchased from an insurance company or financial institution that is subject to licensing or regulation by the Minnesota Department of Commerce or a similar regulatory agency of another state;

(2) does not pay out principal and interest in equal monthly installments; or

(3) does not begin payment at the earliest possible date after annuitization.

(e) Effective for transactions, including the purchase of an annuity, occurring on or after February 8, 2006, by or on behalf of an institutionalized person who has applied for or is receiving long-term care services or the institutionalized person's spouse shall be treated as the disposal of an asset for less than fair market value unless the department is named a preferred remainder beneficiary as described in section 256B.056, subdivision 11. Any subsequent change to the designation of the department as a preferred remainder beneficiary shall result in the annuity being treated as a disposal of assets for less than fair market value. The amount of such transfer shall be the maximum amount the institutionalized person or the institutionalized person's spouse could receive from the annuity or similar financial instrument. Any change in the amount of the income or principal being withdrawn from the annuity or other similar financial instrument at the time of the most recent disclosure shall be deemed to be a transfer of assets for less than fair market value unless the institutionalized person or the institutionalized person's spouse demonstrates that the transaction was for fair market value. In the event a distribution of income or principal has been improperly distributed or disbursed from an annuity or other retirement planning instrument of an institutionalized person or the

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institutionalized person's spouse, a cause of action exists against the individual receiving the improper distribution for the cost of medical assistance services provided or the amount of the improper distribution, whichever is less.

(f) Effective for transactions, including the purchase of an annuity, occurring on or after February 8, 2006, by or on behalf of an institutionalized person applying for or receiving long-term care services shall be treated as a disposal of assets for less than fair market value unless it is:

(1) an annuity described in subsection (b) or (q) of section 408 of the Internal Revenue Code of 1986; or

(2) purchased with proceeds from:

(A) an account or trust described in subsection (a), (c), or (p) of section 408 of the Internal Revenue Code;

(B) a simplified employee pension within the meaning of section 408(k) of the Internal Revenue Code; or

(C) a Roth IRA described in section 408A of the Internal Revenue Code; or

(3) an annuity that is irrevocable and nonassignable; is actuarially sound as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration; and provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

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

(h) This section applies to funds used to purchase a promissory note, loan, or mortgage unless the note, loan, or mortgage:

(1) has a repayment term that is actuarially sound;

(2) provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and

(3) prohibits the cancellation of the balance upon the death of the lender.

In the case of a promissory note, loan, or mortgage that does not meet an exception in clauses (1) to (3), the value of such note, loan, or mortgage shall be the outstanding balance due as of the date of the institutionalized person's request for medical assistance payment of long-term care services.

(i) This section applies to the purchase of a life estate interest in another person's home unless the purchaser resides in the home for a period of at least one year after the date of purchase.

(j) This section applies to transfers into a pooled trust that qualifies under United States Code, title 42, section 1396p(d)(4)(C), by:

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(1) a person age 65 or older or the person's spouse; or

(2) any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of a person age 65 or older or the person's spouse.

[See Note.]

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

Subd. 1b. [Repealed, 2010 c 310 art 5 s 1]

Subd. 2. **Period of ineligibility for long-term care services.** (a) For uncompensated transfers made after August 10, 1993, the number of months of ineligibility for long-term care services shall be the total uncompensated value of the resources transferred divided by the average medical assistance rate for nursing facility services in the state in effect on the date of application. The amount used to calculate the average medical assistance payment rate shall be adjusted each July 1 to reflect payment rates for the previous calendar year. The period of ineligibility begins with the first day of the month after the month in which the assets were transferred except that if one or more uncompensated transfers are made during a period of ineligibility, the total assets transferred during the ineligibility period shall be combined and a penalty period calculated to begin on the first day of the month after the month in which the first uncompensated transfer was made. If the transfer was reported to the local agency after the date that advance notice of a period of ineligibility that affects the next month could be provided to the recipient and the recipient received medical assistance services or the transfer was not reported to the local agency, and the applicant or recipient received medical assistance services during what would have been the period of ineligibility if the transfer had been reported, a cause of action exists against the transferee for that portion of long-term care services provided during the period of ineligibility, or for the uncompensated amount of the transfer, whichever is less. The uncompensated transfer amount is the fair market value of the asset at the time it was given away, sold, or disposed of, less the amount of compensation received. Effective for transfers made on or after March 1, 1996, involving persons who apply for medical assistance on or after April 13, 1996, no cause of action exists for a transfer unless:

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

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

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

(b) For uncompensated transfers made on or after February 8, 2006, the period of ineligibility:

(1) for uncompensated transfers by or on behalf of individuals receiving medical assistance payment of long-term care services, begins the first day of the month following advance notice of the period of ineligibility, but no later than the first day of the month that follows three full calendar months from the date of the report or discovery of the transfer; or

(2) for uncompensated transfers by individuals requesting medical assistance payment of long-term care services, begins the date on which the individual is eligible for medical assistance under the Medicaid state

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plan and would otherwise be receiving long-term care services based on an approved application for such care but for the period of ineligibility resulting from the uncompensated transfer; and

(3) cannot begin during any other period of ineligibility.

(c) If a calculation of a period of ineligibility results in a partial month, payments for long-term care services shall be reduced in an amount equal to the fraction.

(d) In the case of multiple fractional transfers of assets in more than one month for less than fair market value on or after February 8, 2006, the period of ineligibility is calculated by treating the total, cumulative, uncompensated value of all assets transferred during all months on or after February 8, 2006, as one transfer.

(e) A period of ineligibility established under paragraph (b) may be eliminated if all of the assets transferred for less than fair market value used to calculate the period of ineligibility, or cash equal to the value of the assets at the time of the transfer, are returned. A period of ineligibility must not be adjusted if less than the full amount of the transferred assets or the full cash value of the transferred assets are returned.

[See Note.]

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

Subd. 2b. [Repealed, 2010 c 310 art 5 s 1]

Subd. 3. **Homestead exception to transfer prohibition.** (a) An institutionalized person is not ineligible for long-term care services due to a transfer of assets for less than fair market value if the asset transferred was a homestead and:

(1) title to the homestead was transferred to the individual's:

(i) spouse;

(ii) child who is under age 21;

(iii) blind or permanently and totally disabled child as defined in the Supplemental Security Income program;

(iv) sibling who has equity interest in the home and who was residing in the home for a period of at least one year immediately before the date of the individual's admission to the facility; or

(v) son or daughter who was residing in the individual's home for a period of at least two years immediately before the date the individual became an institutionalized person, and who provided care to the individual that, as certified by the individual's attending physician, permitted the individual to reside at home rather than receive care in an institution or facility;

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

(3) the local agency grants a waiver of a penalty resulting from a transfer for less than fair market value because denial of eligibility would cause undue hardship for the individual, based on imminent threat to the individual's health and well-being. Whenever an applicant or recipient is denied eligibility because of a transfer for less than fair market value, the local agency shall notify the applicant or recipient that the applicant or recipient may request a waiver of the penalty if the denial of eligibility will cause undue hardship. With the written consent of the individual or the personal representative of the individual, a long-

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term care facility in which an individual is residing may file an undue hardship waiver request, on behalf of the individual who is denied eligibility for long-term care services on or after July 1, 2006, due to a period of ineligibility resulting from a transfer on or after February 8, 2006. In evaluating a waiver, the local agency shall take into account whether the individual was the victim of financial exploitation, whether the individual has made reasonable efforts to recover the transferred property or resource, and other factors relevant to a determination of hardship. If the local agency does not approve a hardship waiver, the local agency shall issue a written notice to the individual stating the reasons for the denial and the process for appealing the local agency's decision.

(b) When a waiver is granted under paragraph (a), clause (3), a cause of action exists against the person to whom the homestead was transferred for that portion of long-term care services provided within:

(1) 30 months of a transfer made on or before August 10, 1993;

(2) 60 months if the homestead was transferred after August 10, 1993, to a trust or portion of a trust that is considered a transfer of assets under federal law;

(3) 36 months if transferred in any other manner after August 10, 1993, but prior to February 8, 2006; or

(4) 60 months if the homestead was transferred on or after February 8, 2006,

or the amount of the uncompensated transfer, whichever is less, together with the costs incurred due to the action.

[See Note.]

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

Subd. 3b. [Repealed, 2010 c 310 art 5 s 1]

Subd. 4. **Other exceptions to transfer prohibition.** (a) An institutionalized person, as defined in subdivision 1, paragraph (g), who has made, or whose spouse has made a transfer prohibited by subdivision 1, is not ineligible for long-term care services if one of the following conditions applies:

(1) the assets were transferred to the individual's spouse or to another for the sole benefit of the spouse; or

(2) the institutionalized spouse, prior to being institutionalized, transferred assets to a spouse, provided that the spouse to whom the assets were transferred does not then transfer those assets to another person for less than fair market value. (At the time when one spouse is institutionalized, assets must be allocated between the spouses as provided under section 256B.059); or

(3) the assets were transferred to the individual's child who is blind or permanently and totally disabled as determined in the Supplemental Security Income program; or

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

(5) the local agency determines that denial of eligibility for long-term care services would work an undue hardship and grants a waiver of a period of ineligibility resulting from a transfer for less than fair market value based on an imminent threat to the individual's health and well-being. Imminent threat to the individual's health and well-being means that imposing a period of ineligibility would endanger the individual's health or life or cause serious deprivation of food, clothing, or shelter. Whenever an applicant or recipient is denied eligibility because of a transfer for less than fair market value, the local agency shall notify

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the applicant or recipient that the applicant or recipient may request a waiver of the period of ineligibility if the denial of eligibility will cause undue hardship. With the written consent of the individual or the personal representative of the individual, a long-term care facility in which an individual is residing may file an undue hardship waiver request, on behalf of the individual who is denied eligibility for long-term care services on or after July 1, 2006, due to a period of ineligibility resulting from a transfer on or after February 8, 2006; or

(6) for transfers occurring after August 10, 1993, the assets were transferred by the person or the person's spouse: (i) into a trust established for the sole benefit of a son or daughter of any age who is blind or disabled as defined by the Supplemental Security Income program; or (ii) into a trust established for the sole benefit of an individual who is under 65 years of age who is disabled as defined by the Supplemental Security Income program. "For the sole benefit of" has the meaning found in section 256B.059, subdivision 1.

(b) Subject to paragraph (c), when evaluating a hardship waiver, the local agency shall take into account whether the individual was the victim of financial exploitation, whether the individual has made reasonable efforts to recover the transferred property or resource, whether the individual has taken any action to prevent the designation of the department as a remainder beneficiary on an annuity as described in section 256B.056, subdivision 11, and other factors relevant to a determination of hardship.

(c) In the case of an imminent threat to the individual's health and well-being, the local agency shall approve a hardship waiver of the portion of an individual's period of ineligibility resulting from a transfer of assets for less than fair market value by or to a person:

(1) convicted of financial exploitation, fraud, or theft upon the individual for the transfer of assets; or

(2) against whom a report of financial exploitation upon the individual has been substantiated. For purposes of this paragraph, "financial exploitation" and "substantiated" have the meanings given in section 626.5572.

(d) The local agency shall make a determination within 30 days of the receipt of all necessary information needed to make such a determination. If the local agency does not approve a hardship waiver, the local agency shall issue a written notice to the individual stating the reasons for the denial and the process for appealing the local agency's decision. When a waiver is granted, a cause of action exists against the person to whom the assets were transferred for that portion of long-term care services provided within:

(1) 30 months of a transfer made on or before August 10, 1993;

(2) 60 months of a transfer if the assets were transferred after August 30, 1993, to a trust or portion of a trust that is considered a transfer of assets under federal law;

(3) 36 months of a transfer if transferred in any other manner after August 10, 1993, but prior to February 8, 2006; or

(4) 60 months of any transfer made on or after February 8, 2006,

or the amount of the uncompensated transfer, whichever is less, together with the costs incurred due to the action.

[See Note.]

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

Subd. 4b. [Repealed, 2010 c 310 art 5 s 1]

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Subd. 5. [Repealed, 2010 c 310 art 5 s 1]

Subd. 6. **No impairment on realty conveyance, encumbrance.** This section does not invalidate or impair the effectiveness of a conveyance or encumbrance of real estate.

Subd. 7. **Notice of rights.** If a period of ineligibility is imposed under subdivision 2 or 2a, the local agency shall inform the applicant or recipient subject to the penalty of the person's rights under section 325F.71, subdivision 2.

Subd. 8. **Cause of action; transfer prior to death.** (a) A cause of action exists against a transferee who receives assets for less than fair market value, either:

(1) from a person who was a recipient of medical assistance and who made an uncompensated transfer that was known to the county agency but a penalty period could not be implemented under this section due to the death of the person; or

(2) from a person who was a recipient of medical assistance who made an uncompensated transfer that was not known to the county agency and the transfer was made with the intent to hinder, delay, or defraud the state or local agency from recovering as allowed under section 256B.15. In determining intent under this clause, consideration may be given, among other factors, to whether:

(i) the transfer was to a family member;

(ii) the transferor retained possession or control of the property after the transfer;

(iii) the transfer was concealed;

(iv) the transfer included the majority of the transferor's assets;

(v) the value of the consideration received was not reasonably equivalent to the fair market value of the property; and

(vi) the transfer occurred shortly before the death of the transferor.

(b) No cause of action exists under this subdivision unless:

(1) the transferee knew or should have known that the transfer was being made by a person who was receiving medical assistance as described in section 256B.15, subdivision 1, paragraph (b); and

(2) the transferee received the asset without providing a reasonable equivalent fair market value in exchange for the transfer.

(c) The cause of action is for the uncompensated amount of the transfer or the amount of medical assistance paid on behalf of the person, whichever is less. The uncompensated transfer amount is the fair market value of the asset at the time it was given away, sold, or disposed of, less the amount of the compensation received.

Subd. 9. **Filing cause of action; limitation.** (a) The county of financial responsibility under chapter 256G may bring a cause of action under any or all of the following:

(1) subdivision 1, paragraph (e);

(2) subdivision 2, paragraph (a);

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(3) subdivision 3, paragraph (b);

(4) subdivision 4, paragraph (d); and

(5) subdivision 8

on behalf of the claimant who must be the commissioner.

(b) Notwithstanding any other law to the contrary, a cause of action under subdivision 2, paragraph (a) or (b), or 8, must be commenced within six years of the date the local agency determines that a transfer was made for less than fair market value. Notwithstanding any other law to the contrary, a cause of action under subdivision 3, paragraph (b), or 4, clause (5), must be commenced within six years of the date of approval of a waiver of the penalty period for a transfer for less than fair market value based on undue hardship.

History: *1986 c 444; 1989 c 282 art 3 s 52; 1990 c 568 art 3 s 40-42; 1992 c 513 art 7 s 42; 1Sp1993 c 1 art 5 s 35; 1994 c 388 art 1 s 2; 1995 c 207 art 6 s 34-37; 1996 c 451 art 2 s 11-19,62; 2001 c 203 s 7,8,19; 2002 c 220 art 15 s 10-12; 1Sp2003 c 14 art 12 s 24-29; 2004 c 266 s 1; 2005 c 56 s 1; 2005 c 155 art 3 s 1; 2006 c 282 art 17 s 30-33; 2008 c 326 art 1 s 23-28; 2009 c 79 art 5 s 21,22; 2009 c 119 s 4,5; 1Sp2010 c 1 art 24 s 11; 1Sp2011 c 9 art 6 s 86; 2012 c 216 art 13 s 6; 2013 c 107 art 4 s 8-11; 2013 c 125 art 1 s 47*

NOTE: The amendments to subdivisions 1, 2, 3, and 4, by Laws 1995, chapter 207, article 6, sections 34 to 37, are effective retroactive to August 11, 1993, except that portion amending subdivision 2, paragraph (c), is effective retroactive to transfers of income or assets made on or after September 1, 1994. Laws 1995, chapter 207, article 6, section 125, subdivision 2, and Laws 1995, chapter 263, section 6.

NOTE: The amendment to subdivision 2, by adding what is now paragraph (e), by Laws 2009, chapter 79, article 5, section 22, is effective for periods of ineligibility established on or after January 1, 2014, or upon the date when it is no longer subject to maintenance of effort requirements of Public Law 111-148. The commissioner of human services shall notify the revisor of statutes of that date. Laws 2009, chapter 79, article 5, section 22, the effective date, as amended by Laws 2010, First Special Session chapter 1, article 24, section 11, and Laws 2011, First Special Session chapter 9, article 6, section 86.

256B.0596 MENTAL HEALTH CASE MANAGEMENT.

Counties shall contract with eligible providers willing to provide mental health case management services under section 256B.0625, subdivision 20. In order to be eligible, in addition to general provider requirements under this chapter, the provider must:

(1) be willing to provide the mental health case management services; and

(2) have a minimum of at least one contact with the client per week. This section is not intended to limit the ability of a county to provide its own mental health case management services.

History: *1Sp2003 c 2 art 5 s 6; 1Sp2003 c 14 art 12 s 30; 2004 c 288 art 3 s 22*

256B.06 ELIGIBILITY; MIGRANT WORKERS; CITIZENSHIP.

Subdivision 1. [Renumbered 256B.055, subdivision 1]

Subd. 1a. [Renumbered 256B.055, subd 2]

Subd. 1b. [Renumbered 256B.055, subd 3]

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Subd. 1c. [Renumbered 256B.055, subd 4]

Subd. 1d. [Renumbered 256B.055, subd 5]

Subd. 1e. [Renumbered 256B.055, subd 6]

Subd. 1f. [Renumbered 256B.055, subd 7]

Subd. 1g. [Renumbered 256B.055, subd 8]

Subd. 1h. [Renumbered 256B.055, subd 9]

Subd. 1i. [Renumbered 256B.055, subd 10]

Subd. 1j. [Renumbered 256B.055, subd 11]

Subd. 1k. [Renumbered 256B.056, subdivision 1]

Subd. 1l. [Renumbered 256B.056, subd 2]

Subd. 1m. [Renumbered 256B.056, subd 3]

Subd. 1n. [Renumbered 256B.056, subd 4]

Subd. 1o. [Renumbered 256B.056, subd 5]

Subd. 1p. [Renumbered 256B.056, subd 6]

Subd. 1q. [Renumbered 256B.055, subd 12]

Subd. 1r. [Renumbered 256B.056, subd 7]

Subd. 2. [Repealed, 1974 c 525 s 3]

Subd. 3. **Migrant worker.** Notwithstanding any law to the contrary, a migrant worker who meets all of the eligibility requirements of this section except for having a permanent place of abode in another state, shall be eligible for medical assistance and shall have medical needs met by the county in which the worker resides at the time of making application.

Subd. 4. **Citizenship requirements.** (a) Eligibility for medical assistance is limited to citizens of the United States, qualified noncitizens as defined in this subdivision, and other persons residing lawfully in the United States. Citizens or nationals of the United States must cooperate in obtaining satisfactory documentary evidence of citizenship or nationality according to the requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171.

(b) "Qualified noncitizen" means a person who meets one of the following immigration criteria:

(1) admitted for lawful permanent residence according to United States Code, title 8;

(2) admitted to the United States as a refugee according to United States Code, title 8, section 1157;

(3) granted asylum according to United States Code, title 8, section 1158;

(4) granted withholding of deportation according to United States Code, title 8, section 1253(h);

(5) paroled for a period of at least one year according to United States Code, title 8, section 1182(d)(5);

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(6) granted conditional entrant status according to United States Code, title 8, section 1153(a)(7);

(7) determined to be a battered noncitizen by the United States Attorney General according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, title V of the Omnibus Consolidated Appropriations Bill, Public Law 104-200;

(8) is a child of a noncitizen determined to be a battered noncitizen by the United States Attorney General according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, title V, of the Omnibus Consolidated Appropriations Bill, Public Law 104-200; or

(9) determined to be a Cuban or Haitian entrant as defined in section 501(e) of Public Law 96-422, the Refugee Education Assistance Act of 1980.

(c) All qualified noncitizens who were residing in the United States before August 22, 1996, who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance with federal financial participation.

(d) Beginning December 1, 1996, qualified noncitizens who entered the United States on or after August 22, 1996, and who otherwise meet the eligibility requirements of this chapter are eligible for medical assistance with federal participation for five years if they meet one of the following criteria:

(1) refugees admitted to the United States according to United States Code, title 8, section 1157;

(2) persons granted asylum according to United States Code, title 8, section 1158;

(3) persons granted withholding of deportation according to United States Code, title 8, section 1253(h);

(4) veterans of the United States armed forces with an honorable discharge for a reason other than noncitizen status, their spouses and unmarried minor dependent children; or

(5) persons on active duty in the United States armed forces, other than for training, their spouses and unmarried minor dependent children.

Beginning July 1, 2010, children and pregnant women who are noncitizens described in paragraph (b) or who are lawfully present in the United States as defined in Code of Federal Regulations, title 8, section 103.12, and who otherwise meet eligibility requirements of this chapter, are eligible for medical assistance with federal financial participation as provided by the federal Children's Health Insurance Program Reauthorization Act of 2009, Public Law 111-3.

(e) Nonimmigrants who otherwise meet the eligibility requirements of this chapter are eligible for the benefits as provided in paragraphs (f) to (h). For purposes of this subdivision, a "nonimmigrant" is a person in one of the classes listed in United States Code, title 8, section 1101(a)(15).

(f) Payment shall also be made for care and services that are furnished to noncitizens, regardless of immigration status, who otherwise meet the eligibility requirements of this chapter, if such care and services are necessary for the treatment of an emergency medical condition.

(g) For purposes of this subdivision, the term "emergency medical condition" means a medical condition that meets the requirements of United States Code, title 42, section 1396b(v).

(h)(1) Notwithstanding paragraph (g), services that are necessary for the treatment of an emergency medical condition are limited to the following:

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(i) services delivered in an emergency room or by an ambulance service licensed under chapter 144E that are directly related to the treatment of an emergency medical condition;

(ii) services delivered in an inpatient hospital setting following admission from an emergency room or clinic for an acute emergency condition; and

(iii) follow-up services that are directly related to the original service provided to treat the emergency medical condition and are covered by the global payment made to the provider.

(2) Services for the treatment of emergency medical conditions do not include:

(i) services delivered in an emergency room or inpatient setting to treat a nonemergency condition;

(ii) organ transplants, stem cell transplants, and related care;

(iii) services for routine prenatal care;

(iv) continuing care, including long-term care, nursing facility services, home health care, adult day care, day training, or supportive living services;

(v) elective surgery;

(vi) outpatient prescription drugs, unless the drugs are administered or dispensed as part of an emergency room visit;

(vii) preventative health care and family planning services;

(viii) rehabilitation services;

(ix) physical, occupational, or speech therapy;

(x) transportation services;

(xi) case management;

(xii) prosthetics, orthotics, durable medical equipment, or medical supplies;

(xiii) dental services;

(xiv) hospice care;

(xv) audiology services and hearing aids;

(xvi) podiatry services;

(xvii) chiropractic services;

(xviii) immunizations;

(xix) vision services and eyeglasses;

(xx) waiver services;

(xxi) individualized education programs; or

(xxii) chemical dependency treatment.

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(i) Pregnant noncitizens who are ineligible for federally funded medical assistance because of immigration status, are not covered by a group health plan or health insurance coverage according to Code of Federal Regulations, title 42, section 457.310, and who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance through the period of pregnancy, including labor and delivery, and 60 days postpartum, to the extent federal funds are available under title XXI of the Social Security Act, and the state children's health insurance program.

(j) Beginning October 1, 2003, persons who are receiving care and rehabilitation services from a nonprofit center established to serve victims of torture and are otherwise ineligible for medical assistance under this chapter are eligible for medical assistance without federal financial participation. These individuals are eligible only for the period during which they are receiving services from the center. Individuals eligible under this paragraph shall not be required to participate in prepaid medical assistance. The nonprofit center referenced under this paragraph may establish itself as a provider of mental health targeted case management services through a county contract under section 256.0112, subdivision 6. If the nonprofit center is unable to secure a contract with a lead county in its service area, then, notwithstanding the requirements of section 256B.0625, subdivision 20, the commissioner may negotiate a contract with the nonprofit center for provision of mental health targeted case management services. When serving clients who are not the financial responsibility of their contracted lead county, the nonprofit center must gain the concurrence of the county of financial responsibility prior to providing mental health targeted case management services for those clients.

(k) Notwithstanding paragraph (h), clause (2), the following services are covered as emergency medical conditions under paragraph (f) except where coverage is prohibited under federal law:

(1) dialysis services provided in a hospital or freestanding dialysis facility; and

(2) surgery and the administration of chemotherapy, radiation, and related services necessary to treat cancer if the recipient has a cancer diagnosis that is not in remission and requires surgery, chemotherapy, or radiation treatment.

(l) Effective July 1, 2013, recipients of emergency medical assistance under this subdivision are eligible for coverage of the elderly waiver services provided under section 256B.0915, and coverage of rehabilitative services provided in a nursing facility. The age limit for elderly waiver services does not apply. In order to qualify for coverage, a recipient of emergency medical assistance is subject to the assessment and reassessment requirements of section 256B.0911. Initial and continued enrollment under this paragraph is subject to the limits of available funding.

Subd. 5. **Deeming of sponsor income and resources.** When determining eligibility for any federal or state funded medical assistance under this section, the income and resources of all noncitizens shall be deemed to include their sponsors' income and resources as required under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, title IV, Public Law 104-193, sections 421 and 422, and subsequently set out in federal rules. This section is effective May 1, 1997. Beginning July 1, 2010, sponsor deeming does not apply to pregnant women and children who are qualified noncitizens, as described in subdivision 4, paragraph (b).

History: *Ex1967 c 16 s 6; 1969 c 841 s 1; 1973 c 717 s 18; 1974 c 525 s 1,2; 1975 c 247 s 10; 1976 c 236 s 3; 1977 c 448 s 6; 1978 c 760 s 1; 1979 c 309 s 4; 1980 c 509 s 106; 1980 c 527 s 1; 1981 c 360 art 2 s 28; 1Sp1981 c 2 s 14; 3Sp1981 c 2 art 1 s 32; 3Sp1981 c 3 s 17; 1982 c 553 s 6; 1982 c 640 s 5; 1983 c 312 art 5 s 15; 1984 c 422 s 1; 1984 c 534 s 22; 1984 c 654 art 5 s 58; 1985 c 248 s 70; 1985 c 252*

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s 21; 1986 c 444; 1Sp1986 c 1 art 8 s 5; 1987 c 403 art 2 s 79,80; 1988 c 689 art 2 s 144,145,268; 1991 c 199 art 2 s 1; 1995 c 207 art 6 s 38; 1997 c 85 art 3 s 19,20; 1997 c 203 art 12 s 2; 1998 c 407 art 4 s 19; 1Sp2003 c 14 art 12 s 31; 2004 c 288 art 6 s 21; 1Sp2005 c 4 art 8 s 28; 2006 c 282 art 17 s 34; 2007 c 13 art 1 s 25; 2008 c 286 art 1 s 6; 2009 c 79 art 5 s 23,24; 2009 c 173 art 1 s 19; 1Sp2011 c 9 art 6 s 27; 2013 c 108 art 1 s 25; art 6 s 7; 2014 c 312 art 29 s 5

256B.061 ELIGIBILITY; RETROACTIVE EFFECT; RESTRICTIONS.

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.

History: *1973 c 717 s 3; 1983 c 312 art 5 s 16; 1986 c 444; 1999 c 245 art 4 s 36; 1Sp2003 c 14 art 12 s 32*

256B.0615 MENTAL HEALTH CERTIFIED PEER SPECIALIST.

Subdivision 1. **Scope.** Medical assistance covers mental health certified peers specialists services, as established in subdivision 2, subject to federal approval, if provided to recipients who are eligible for services under sections 256B.0622, 256B.0623, and 256B.0624 and are provided by a certified peer specialist who has completed the training under subdivision 5.

Subd. 2. **Establishment.** The commissioner of human services shall establish a certified peer specialists program model, which:

(1) provides nonclinical peer support counseling by certified peer specialists;

(2) provides a part of a wraparound continuum of services in conjunction with other community mental health services;

(3) is individualized to the consumer; and

(4) promotes socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.

Subd. 3. **Eligibility.** Peer support services may be made available to consumers of (1) intensive rehabilitative mental health services under section 256B.0622; (2) adult rehabilitative mental health services under section 256B.0623; and (3) crisis stabilization and mental health mobile crisis intervention services under section 256B.0624.

Subd. 4. **Peer support specialist program providers.** The commissioner shall develop a process to certify peer support specialist programs, in accordance with the federal guidelines, in order for the program to bill for reimbursable services. Peer support programs may be freestanding or within existing mental health community provider centers.

Subd. 5. **Certified peer specialist training and certification.** The commissioner of human services shall develop a training and certification process for certified peer specialists, who must be at least 21 years of age and have a high school diploma or its equivalent. The candidates must have had a primary diagnosis of mental illness, be a current or former consumer of mental health services, and must demonstrate leadership

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and advocacy skills and a strong dedication to recovery. The training curriculum must teach participating consumers specific skills relevant to providing peer support to other consumers. In addition to initial training and certification, the commissioner shall develop ongoing continuing educational workshops on pertinent issues related to peer support counseling.

History: *2007 c 147 art 8 s 16; 2009 c 167 s 7,8; 2014 c 312 art 29 s 6*

256B.0616 MENTAL HEALTH CERTIFIED FAMILY PEER SPECIALIST.

Subdivision 1. **Scope.** Medical assistance covers mental health certified family peer specialists services, as established in subdivision 2, subject to federal approval, if provided to recipients who have an emotional disturbance or severe emotional disturbance under chapter 245, and are provided by a certified family peer specialist who has completed the training under subdivision 5. A family peer specialist cannot provide services to the peer specialist's family.

Subd. 2. **Establishment.** The commissioner of human services shall establish a certified family peer specialists program model which:

(1) provides nonclinical family peer support counseling, building on the strengths of families and helping them achieve desired outcomes;

(2) collaborates with others providing care or support to the family;

(3) provides nonadversarial advocacy;

(4) promotes the individual family culture in the treatment milieu;

(5) links parents to other parents in the community;

(6) offers support and encouragement;

(7) assists parents in developing coping mechanisms and problem-solving skills;

(8) promotes resiliency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services;

(9) establishes and provides peer-led parent support groups; and

(10) increases the child's ability to function better within the child's home, school, and community by educating parents on community resources, assisting with problem solving, and educating parents on mental illnesses.

Subd. 3. **Eligibility.** Family peer support services may be located in inpatient hospitalization, partial hospitalization, residential treatment, treatment foster care, day treatment, children's therapeutic services and supports, or crisis services.

Subd. 4. **Peer support specialist program providers.** The commissioner shall develop a process to certify family peer support specialist programs, in accordance with the federal guidelines, in order for the program to bill for reimbursable services. Family peer support programs must operate within an existing mental health community provider or center.

Subd. 5. **Certified family peer specialist training and certification.** The commissioner shall develop a training and certification process for certified family peer specialists who must be at least 21 years of age

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and have a high school diploma or its equivalent. The candidates must have raised or be currently raising a child with a mental illness, have had experience navigating the children's mental health system, and must demonstrate leadership and advocacy skills and a strong dedication to family-driven and family-focused services. The training curriculum must teach participating family peer specialists specific skills relevant to providing peer support to other parents. In addition to initial training and certification, the commissioner shall develop ongoing continuing educational workshops on pertinent issues related to family peer support counseling.

History: *2013 c 108 art 4 s 15*

256B.062 [Repealed, 1998 c 407 art 6 s 12,118]

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

Subdivision 1. [Repealed, 2002 c 375 art 2 s 56]

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

(1) "home care service recipients" means those individuals receiving the following services under sections 256B.0651 to 256B.0654 and 256B.0659: skilled nursing visits, home health aide visits, home care nursing, personal care assistants, or therapies provided through a home health agency;

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

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

(4) "relocation targeted case management" includes the provision of both county targeted case management and public or private vendor service coordination services for the purpose of assisting recipients to gain access to needed services and supports if they choose to move from an institution to the community. Relocation targeted case management may be provided during the lesser of:

(i) the last 180 consecutive days of an eligible recipient's institutional stay; or

(ii) the limits and conditions which apply to federal Medicaid funding for this service; and

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

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

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

(2) medical assistance eligible persons receiving home care services, who are not eligible for any other medical assistance reimbursable case management service, are eligible for home care targeted case management services beginning July 1, 2005.

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Subd. 4. **Relocation targeted county case management provider qualifications.** (a) A relocation targeted county case management provider is an enrolled medical assistance provider who is determined by the commissioner to have all of the following characteristics:

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

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

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

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

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

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

(b) A provider of targeted case management under section 256B.0625, subdivision 20, may be deemed a certified provider of relocation targeted case management.

(c) A relocation targeted county case management provider may subcontract with another provider to deliver relocation targeted case management services. Subcontracted providers must demonstrate the ability to provide the services outlined in subdivision 6, and have a procedure in place that notifies the recipient and the recipient's legal representative of any conflict of interest if the contracted targeted case management provider also provides, or will provide, the recipient's services and supports. Counties must require that contracted providers must provide information on all conflicts of interest and obtain the recipient's informed consent or provide the recipient with alternatives.

Subd. 5. **Specific provider qualifications.** Providers of home care targeted case management and relocation service coordination must meet the qualifications under subdivision 4 for county vendors or the qualifications and certification standards under paragraphs (a) and (b) for private vendors.

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

(b) Both home care targeted case management providers and relocation service coordination providers are enrolled medical assistance providers who have a minimum of a bachelor's degree or a license in a health or human services field, comparable training and two years of experience in human services, or who have been credentialed by an American Indian tribe under section 256B.02, subdivision 7, and have been determined by the commissioner to have all of the following characteristics:

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

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

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

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

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

(6) have no financial interest in the provision of out-of-home residential services to persons for whom home care targeted case management or relocation service coordination is provided; and

(7) if a provider has a financial interest in services other than out-of-home residential services provided to persons for whom home care targeted case management or relocation service coordination is also provided, the county must determine each year that:

(i) any possible conflict of interest is explained annually at a face-to-face meeting and in writing and the person provides written informed consent consistent with section 256B.77, subdivision 2, paragraph (p); and

(ii) information on a range of other feasible service provider options has been provided.

(c) The state of Minnesota, a county board, or agency acting on behalf of a county board shall not be liable for damages, injuries, or liabilities sustained because of services provided to a client by a private service coordination vendor.

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

(1) assessment of the recipient's need for targeted case management services and for persons choosing to relocate, the county must provide service coordination provider options at the first contact and upon request;

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

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

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

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

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

(7) assisting individuals in order to access needed services, including travel to conduct a visit with the recipient or other relevant person necessary to develop or implement the goals of the individual service plan; and

(8) coordinating with the institution discharge planner before the recipient's discharge.

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(b) Relocation targeted county case management includes services under paragraph (a), clauses (1), (2), and (4). Relocation service coordination includes services under paragraph (a), clauses (3) and (5) to (8). Home care targeted case management includes services under paragraph (a), clauses (1) to (8).

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

(a) For relocation targeted case management, an eligible recipient must be assigned a county case manager who visits the person within 20 working days of requesting a case manager from their county of financial responsibility as determined under chapter 256G.

(1) If a county agency, its contractor, or federally recognized tribe does not provide case management services as required, the recipient may obtain relocation service coordination from a provider qualified under subdivision 5.

(2) The commissioner may waive the provider requirements in subdivision 4, paragraph (a), clauses (1) and (4), to ensure recipient access to the assistance necessary to move from an institution to the community. The recipient or the recipient's legal guardian shall provide written notice to the county or tribe of the decision to obtain services from an alternative provider.

(3) Providers of relocation targeted case management enrolled under this subdivision shall:

(i) meet the provider requirements under subdivision 4 that are not waived by the commissioner;

(ii) be qualified to provide the services specified in subdivision 6;

(iii) coordinate efforts with local social service agencies and tribes; and

(iv) comply with the conflict of interest provisions established under subdivision 4, paragraph (c).

(4) Local social service agencies and federally recognized tribes shall cooperate with providers certified by the commissioner under this subdivision to facilitate the recipient's successful relocation from an institution to the community.

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

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

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

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

(1) for relocation targeted case management, case managers may bill for direct case management activities, including face-to-face and telephone contacts, in the lesser of:

(i) 180 days preceding an eligible recipient's discharge from an institution; or

(ii) the limits and conditions which apply to federal Medicaid funding for this service;

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

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

Subd. 11. **Notice of relocation assistance.** The commissioner shall establish a process with the Centers for Independent Living that allows a person residing in a Minnesota nursing facility to receive needed information, consultation, and assistance from one of the centers about the available community support options that may enable the person to relocate to the community, if the person: (1) is under the age of 65, (2) has indicated a desire to live in the community, and (3) has signed a release of information authorized by the person or the person's appointed legal representative. The process established under this subdivision shall be coordinated with the long-term care consultation service activities established in section 256B.0911.

History: *1Sp2001 c 9 art 2 s 39; art 3 s 20-28,77; 1Sp2003 c 14 art 3 s 17,18; 2005 c 56 s 1; 1Sp2005 c 4 art 7 s 6-12; 2007 c 147 art 6 s 17; 2008 c 363 art 15 s 1-3; 2009 c 79 art 6 s 8; 2014 c 262 art 5 s 6; 2014 c 291 art 9 s 5*

256B.0622 INTENSIVE REHABILITATIVE MENTAL HEALTH SERVICES.

Subdivision 1. **Scope.** Subject to federal approval, medical assistance covers medically necessary, intensive nonresidential and residential rehabilitative mental health services as defined in subdivision 2, for recipients as defined in subdivision 3, when the services are provided by an entity meeting the standards in this section.

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

(a) "Intensive nonresidential rehabilitative mental health services" means adult rehabilitative mental health services as defined in section 256B.0623, subdivision 2, paragraph (a), except that these services are provided by a multidisciplinary staff using a total team approach consistent with assertive community treatment, the Fairweather Lodge treatment model, as defined by the standards established by the National Coalition for Community Living, and other evidence-based practices, and directed to recipients with a serious mental illness who require intensive services.

(b) "Intensive residential rehabilitative mental health services" means short-term, time-limited services provided in a residential setting to recipients who are in need of more restrictive settings and are at risk of significant functional deterioration if they do not receive these services. Services are designed to develop and enhance psychiatric stability, personal and emotional adjustment, self-sufficiency, and skills to live in a more independent setting. Services must be directed toward a targeted discharge date with specified client outcomes and must be consistent with the Fairweather Lodge treatment model as defined in paragraph (a), and other evidence-based practices.

(c) "Evidence-based practices" are nationally recognized mental health services that are proven by substantial research to be effective in helping individuals with serious mental illness obtain specific treatment goals.

(d) "Overnight staff" means a member of the intensive residential rehabilitative mental health treatment team who is responsible during hours when recipients are typically asleep.

(e) "Treatment team" means all staff who provide services under this section to recipients. At a minimum, this includes the clinical supervisor, mental health professionals as defined in section 245.462,

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subdivision 18, clauses (1) to (6); mental health practitioners as defined in section 245.462, subdivision 17; mental health rehabilitation workers under section 256B.0623, subdivision 5, clause (3); and certified peer specialists under section 256B.0615.

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

(1) is age 18 or older;

(2) is eligible for medical assistance;

(3) is diagnosed with a mental illness;

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

(5) has one or more of the following: a history of two or more inpatient hospitalizations in the past year, significant independent living instability, homelessness, or very frequent use of mental health and related services yielding poor outcomes; and

(6) in the written opinion of a licensed mental health professional, has the need for mental health services that cannot be met with other available community-based services, or is likely to experience a mental health crisis or require a more restrictive setting if intensive rehabilitative mental health services are not provided.

Subd. 4. **Provider certification and contract requirements.** (a) The intensive nonresidential rehabilitative mental health services provider must:

(1) have a contract with the host county to provide intensive adult rehabilitative mental health services; and

(2) be certified by the commissioner as being in compliance with this section and section 256B.0623.

(b) The intensive residential rehabilitative mental health services provider must:

(1) be licensed under Minnesota Rules, parts 9520.0500 to 9520.0670;

(2) not exceed 16 beds per site;

(3) comply with the additional standards in this section; and

(4) have a contract with the host county to provide these services.

(c) The commissioner shall develop procedures for counties and providers to submit contracts and other documentation as needed to allow the commissioner to determine whether the standards in this section are met.

Subd. 5. **Standards applicable to both nonresidential and residential providers.** (a) Services must be provided by qualified staff as defined in section 256B.0623, subdivision 5, who are trained and supervised according to section 256B.0623, subdivision 6, except that mental health rehabilitation workers acting as overnight staff are not required to comply with section 256B.0623, subdivision 5, clause (3)(iv).

(b) The clinical supervisor must be an active member of the treatment team. The treatment team must meet with the clinical supervisor at least weekly to discuss recipients' progress and make rapid adjustments to meet recipients' needs. The team meeting shall include recipient-specific case reviews and general treatment

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discussions among team members. Recipient-specific case reviews and planning must be documented in the individual recipient's treatment record.

(c) Treatment staff must have prompt access in person or by telephone to a mental health practitioner or mental health professional. The provider must have the capacity to promptly and appropriately respond to emergent needs and make any necessary staffing adjustments to assure the health and safety of recipients.

(d) The initial functional assessment must be completed within ten days of intake and updated at least every three months or prior to discharge from the service, whichever comes first.

(e) The initial individual treatment plan must be completed within ten days of intake and reviewed and updated at least monthly with the recipient.

Subd. 6. **Standards for intensive residential rehabilitative mental health services.** (a) The provider of intensive residential services must have sufficient staff to provide 24-hour-per-day coverage to deliver the rehabilitative services described in the treatment plan and to safely supervise and direct the activities of recipients given the recipient's level of behavioral and psychiatric stability, cultural needs, and vulnerability. The provider must have the capacity within the facility to provide integrated services for chemical dependency, illness management services, and family education when appropriate.

(b) At a minimum:

(1) staff must be available and provide direction and supervision whenever recipients are present in the facility;

(2) staff must remain awake during all work hours;

(3) there must be a staffing ratio of at least one to nine recipients for each day and evening shift. If more than nine recipients are present at the residential site, there must be a minimum of two staff during day and evening shifts, one of whom must be a mental health practitioner or mental health professional;

(4) if services are provided to recipients who need the services of a medical professional, the provider shall assure that these services are provided either by the provider's own medical staff or through referral to a medical professional; and

(5) the provider must assure the timely availability of a licensed registered nurse, either directly employed or under contract, who is responsible for ensuring the effectiveness and safety of medication administration in the facility and assessing patients for medication side effects and drug interactions.

Subd. 7. **Additional standards for nonresidential services.** The standards in this subdivision apply to intensive nonresidential rehabilitative mental health services.

(1) The treatment team must use team treatment, not an individual treatment model.

(2) The clinical supervisor must function as a practicing clinician at least on a part-time basis.

(3) The staffing ratio must not exceed ten recipients to one full-time equivalent treatment team position.

(4) Services must be available at times that meet client needs.

(5) The treatment team must actively and assertively engage and reach out to the recipient's family members and significant others, after obtaining the recipient's permission.

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(6) The treatment team must establish ongoing communication and collaboration between the team, family, and significant others and educate the family and significant others about mental illness, symptom management, and the family's role in treatment.

(7) The treatment team must provide interventions to promote positive interpersonal relationships.

Subd. 8. **Medical assistance payment for intensive rehabilitative mental health services.** (a) Payment for residential and nonresidential services in this section shall be based on one daily rate per provider inclusive of the following services received by an eligible recipient in a given calendar day: all rehabilitative services under this section, staff travel time to provide rehabilitative services under this section, and nonresidential crisis stabilization services under section 256B.0624.

(b) Except as indicated in paragraph (c), payment will not be made to more than one entity for each recipient for services provided under this section on a given day. If services under this section are provided by a team that includes staff from more than one entity, the team must determine how to distribute the payment among the members.

(c) The commissioner shall determine one rate for each provider that will bill medical assistance for residential services under this section and one rate for each nonresidential provider. If a single entity provides both services, one rate is established for the entity's residential services and another rate for the entity's nonresidential services under this section. A provider is not eligible for payment under this section without authorization from the commissioner. The commissioner shall develop rates using the following criteria:

(1) the cost for similar services in the local trade area;

(2) the provider's cost for services shall include direct services costs, other program costs, and other costs determined as follows:

(i) the direct services costs must be determined using actual costs of salaries, benefits, payroll taxes, and training of direct service staff and service-related transportation;

(ii) other program costs not included in item (i) must be determined as a specified percentage of the direct services costs as determined by item (i). The percentage used shall be determined by the commissioner based upon the average of percentages that represent the relationship of other program costs to direct services costs among the entities that provide similar services;

(iii) in situations where a provider of intensive residential services can demonstrate actual program-related physical plant costs in excess of the group residential housing reimbursement, the commissioner may include these costs in the program rate, so long as the additional reimbursement does not subsidize the room and board expenses of the program;

(iv) intensive nonresidential services physical plant costs must be reimbursed as part of the costs described in item (ii); and

(v) up to an additional five percent of the total rate must be added to the program rate as a quality incentive based upon the entity meeting performance criteria specified by the commissioner;

(3) actual cost is defined as costs which are allowable, allocable, and reasonable, and consistent with federal reimbursement requirements under Code of Federal Regulations, title 48, chapter 1, part 31, relating to for-profit entities, and Office of Management and Budget Circular Number A-122, relating to nonprofit entities;

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(4) the number of service units;

(5) the degree to which recipients will receive services other than services under this section;

(6) the costs of other services that will be separately reimbursed; and

(7) input from the local planning process authorized by the adult mental health initiative under section 245.4661, regarding recipients' service needs.

(d) The rate for intensive rehabilitative mental health services must exclude room and board, as defined in section 256I.03, subdivision 6, and services not covered under this section, such as partial hospitalization, home care, and inpatient services. Physician services that are not separately billed may be included in the rate to the extent that a psychiatrist is a member of the treatment team.

(e) When services under this section are provided by an intensive nonresidential service provider, case management functions must be an integral part of the team.

(f) The rate for a provider must not exceed the rate charged by that provider for the same service to other payors.

(g) The rates for existing programs must be established prospectively based upon the expenditures and utilization over a prior 12-month period using the criteria established in paragraph (c).

(h) Entities who discontinue providing services must be subject to a settle-up process whereby actual costs and reimbursement for the previous 12 months are compared. In the event that the entity was paid more than the entity's actual costs plus any applicable performance-related funding due the provider, the excess payment must be reimbursed to the department. If a provider's revenue is less than actual allowed costs due to lower utilization than projected, the commissioner may reimburse the provider to recover its actual allowable costs. The resulting adjustments by the commissioner must be proportional to the percent of total units of service reimbursed by the commissioner.

(i) A provider may request of the commissioner a review of any rate-setting decision made under this subdivision.

Subd. 8a. [Repealed, 2011 c 86 s 23]

Subd. 9. **Provider enrollment; rate setting for county-operated entities.** Counties that employ their own staff to provide services under this section shall apply directly to the commissioner for enrollment and rate setting. In this case, a county contract is not required and the commissioner shall perform the program review and rate setting duties which would otherwise be required of counties under this section.

Subd. 10. **Provider enrollment; rate setting for specialized program.** A provider proposing to serve a subpopulation of eligible recipients may bypass the county approval procedures in this section and receive approval for provider enrollment and rate setting directly from the commissioner under the following circumstances:

(1) the provider demonstrates that the subpopulation to be served requires a specialized program which is not available from county-approved entities; and

(2) the subpopulation to be served is of such a low incidence that it is not feasible to develop a program serving a single county or regional group of counties.

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For providers meeting the criteria in clauses (1) and (2), the commissioner shall perform the program review and rate setting duties which would otherwise be required of counties under this section.

History: *1Sp2003 c 14 art 3 s 19; 2004 c 288 art 3 s 23; 1Sp2005 c 4 art 2 s 7; 2007 c 147 art 8 s 17; 2009 c 79 art 7 s 14; 2009 c 167 s 9,10; 2011 c 86 s 11*

256B.0623 ADULT REHABILITATIVE MENTAL HEALTH SERVICES COVERED.

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

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

(a) "Adult rehabilitative mental health services" means mental health services which are rehabilitative and enable the recipient to develop and enhance psychiatric stability, social competencies, personal and emotional adjustment, independent living, parenting skills, and community skills, when these abilities are impaired by the symptoms of mental illness. Adult rehabilitative mental health services are also appropriate when provided to enable a recipient to retain stability and functioning, if the recipient would be at risk of significant functional decompensation or more restrictive service settings without these services.

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

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

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

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

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

(1) is age 18 or older;

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

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

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

Subd. 4. **Provider entity standards.** (a) The provider entity must be certified by the state following the certification process and procedures developed by the commissioner.

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

(c) A noncounty provider entity must obtain additional certification from each county in which it will provide services. The additional certification must be based on the adequacy of the entity's knowledge of that county's local health and human service system, and the ability of the entity to coordinate its services with the other services available in that county. A county-operated entity must obtain this additional certification from any other county in which it will provide services.

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

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

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

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

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

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

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

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

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

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

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

(9) ensure that services are coordinated with other recipient mental health services providers and the county mental health authority and the federally recognized American Indian authority and necessary others

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after obtaining the consent of the recipient. Services must also be coordinated with the recipient's case manager or care coordinator if the recipient is receiving case management or care coordination services;

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

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

(12) submit information as required by the state;

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

(14) keep all necessary records required by law;

(15) deliver services as required by section 245.461;

(16) comply with all applicable laws;

(17) be an enrolled Medicaid provider;

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

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

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

(1) a mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6). If the recipient has a current diagnostic assessment by a licensed mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6), recommending receipt of adult mental health rehabilitative services, the definition of mental health professional for purposes of this section includes a person who is qualified under section 245.462, subdivision 18, clause (7), and who holds a current and valid national certification as a certified rehabilitation counselor or certified psychosocial rehabilitation practitioner;

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

(3) a certified peer specialist under section 256B.0615. The certified peer specialist must work under the clinical supervision of a mental health professional; or

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

(i) is at least 21 years of age;

(ii) has a high school diploma or equivalent;

(iii) has successfully completed 30 hours of training during the two years immediately prior to the date of hire, or before provision of direct services, in all of the following areas: recipient rights, recipient-

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

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

(A) has an associate of arts degree or two years full-time postsecondary education in one of the behavioral sciences or human services; is a registered nurse without a bachelor's degree; or who within the previous ten years has:

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

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

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

(B)(1) is fluent in the non-English language or competent in the culture of the ethnic group to which at least 20 percent of the mental health rehabilitation worker's clients belong;

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

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

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

(5) has 15 hours of additional continuing education on mental health topics during the first year of employment and 15 hours during every additional year of employment.

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

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

(c) Clinical supervision may be provided by a full- or part-time qualified professional employed by or under contract with the provider entity. Clinical supervision may be provided by interactive videoconferencing according to procedures developed by the commissioner. A mental health professional providing clinical supervision of staff delivering adult rehabilitative mental health services must provide the following guidance:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) an annual performance review;

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

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

(4) evidence of academic degree and qualifications;

(5) a copy of professional license;

(6) any job performance recognition and disciplinary actions;

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

(8) all clinical supervision provided; and

(9) documentation of compliance with continuing education requirements.

Subd. 8. **Diagnostic assessment.** Providers of adult rehabilitative mental health services must complete a diagnostic assessment as defined in section 245.462, subdivision 9, within five days after the recipient's second visit or within 30 days after intake, whichever occurs first. In cases where a diagnostic assessment is available that reflects the recipient's current status, and has been completed within three years preceding admission, an adult diagnostic assessment update must be completed. An update shall include a face-to-face interview with the recipient and a written summary by a mental health professional of the recipient's current mental health status and service needs. If the recipient's mental health status has changed significantly since the adult's most recent diagnostic assessment, a new diagnostic assessment is required.

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

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

(1) Individual treatment plan means a plan of intervention, treatment, and services for an individual recipient written by a mental health professional or by a mental health practitioner under the clinical

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

(2) The individual treatment plan must include:

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

(ii) the recipient's strengths and resources;

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

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

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

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

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

(viii) clear progress notes on outcome of goals.

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

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

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

(2) functional assessments;

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

(4) recipient history;

(5) signed release forms;

(6) recipient health information and current medications;

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(7) emergency contacts for the recipient;

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

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

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

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

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

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

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

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

(1) recipient transportation services;

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

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

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

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

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

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

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

(9) outreach services to potential recipients;

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

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

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

History: *1Sp2001 c 9 art 9 s 39; 2002 c 277 s 11; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 3 s 20-24; 2007 c 147 art 8 s 18; 2009 c 79 art 7 s 15; 2009 c 167 s 11; 2011 c 86 s 12,13; 2013 c 108 art 4 s 16; 2014 c 291 art 4 s 58*

256B.0624 ADULT CRISIS RESPONSE SERVICES COVERED.

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

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

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

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

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

(c) "Mental health crisis assessment" means an immediate face-to-face assessment by a physician, a mental health professional, or mental health practitioner under the clinical supervision of a mental health professional, following a screening that suggests that the adult may be experiencing a mental health crisis or mental health emergency situation. It includes, when feasible, assessing whether the person might be willing to voluntarily accept treatment, determining whether the person has an advance directive, and obtaining information and history from involved family members or caretakers.

(d) "Mental health mobile crisis intervention services" means face-to-face, short-term intensive mental health services initiated during a mental health crisis or mental health emergency to help the recipient cope with immediate stressors, identify and utilize available resources and strengths, engage in voluntary treatment, and begin to return to the recipient's baseline level of functioning. The services, including screening and treatment plan recommendations, must be culturally and linguistically appropriate.

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

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

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

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

(5) The team must be available to individuals who are experiencing a co-occurring substance use disorder, who do not need the level of care provided in a detoxification facility.

(6) The treatment plan must include recommendations for any needed crisis stabilization services for the recipient, including engagement in treatment planning and family psychoeducation.

(e) "Mental health crisis stabilization services" means individualized mental health services provided to a recipient following crisis intervention services which are designed to restore the recipient to the recipient's prior functional level. Mental health crisis stabilization services may be provided in the recipient's home, the home of a family member or friend of the recipient, another community setting, or a short-term supervised, licensed residential program. Mental health crisis stabilization does not include partial hospitalization or day treatment. Mental health crisis stabilization services includes family psychoeducation.

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

(1) is age 18 or older;

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

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

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

(1) is a county board operated entity; or

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

(b) The adult mental health crisis response services provider entity must have the capacity to meet and carry out the following standards:

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

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

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

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

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

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

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

(8) is able to coordinate these services with county emergency services, community hospitals, ambulance, transportation services, social services, law enforcement, and mental health crisis services through regularly scheduled interagency meetings;

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

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

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

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

(13) maintains staff training and personnel files;

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

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

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

(17) is an enrolled medical assistance provider; and

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

Subd. 4a. **Alternative provider standards.** If a county demonstrates that, due to geographic or other barriers, it is not feasible to provide mobile crisis intervention services according to the standards in subdivision 4, paragraph (b), clause (9), the commissioner may approve a crisis response provider based on an alternative plan proposed by a county or group of counties. The alternative plan must:

(1) result in increased access and a reduction in disparities in the availability of crisis services;

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(2) provide mobile services outside of the usual nine-to-five office hours and on weekends and holidays; and

(3) comply with standards for emergency mental health services in section 245.469.

Subd. 5. **Mobile crisis intervention staff qualifications.** For provision of adult mental health mobile crisis intervention services, a mobile crisis intervention team is comprised of at least two mental health professionals as defined in section 245.462, subdivision 18, clauses (1) to (6), or a combination of at least one mental health professional and one mental health practitioner as defined in section 245.462, subdivision 17, with the required mental health crisis training and under the clinical supervision of a mental health professional on the team. The team must have at least two people with at least one member providing on-site crisis intervention services when needed. Team members must be experienced in mental health assessment, crisis intervention techniques, treatment engagement strategies, working with families, and clinical decision-making under emergency conditions and have knowledge of local services and resources. The team must recommend and coordinate the team's services with appropriate local resources such as the county social services agency, mental health services, and local law enforcement when necessary.

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

(b) If a crisis exists, a crisis assessment must be completed. A crisis assessment evaluates any immediate needs for which emergency services are needed and, as time permits, the recipient's current life situation, sources of stress, mental health problems and symptoms, strengths, cultural considerations, support network, vulnerabilities, current functioning, and the recipient's preferences as communicated directly by the recipient, or as communicated in a health care directive as described in chapters 145C and 253B, the treatment plan described under paragraph (d), a crisis prevention plan, or a wellness recovery action plan.

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

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

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

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

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coordinated with the case manager. If the recipient is unable to follow up on the referral, the team must link the recipient to the service and follow up to ensure the recipient is receiving the service.

(g) If the recipient's crisis is stabilized and the recipient does not have an advance directive, the case manager or crisis team shall offer to work with the recipient to develop one.

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

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

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

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

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

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

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

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

(1) be a mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6);

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

(3) be a certified peer specialist under section 256B.0615. The certified peer specialist must work under the clinical supervision of a mental health professional; or

(4) be a mental health rehabilitation worker who meets the criteria in section 256B.0623, subdivision 5, clause (4); works under the direction of a mental health practitioner as defined in section 245.462, sub-

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division 17, or under direction of a mental health professional; and works under the clinical supervision of a mental health professional.

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

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

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

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

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

(4) the mental health professional must:

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

(ii) document the consultation; and

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

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

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

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

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

(2) signed release forms;

(3) recipient health information and current medications;

(4) emergency contacts for the recipient;

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

(6) required clinical supervision by mental health professionals;

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

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

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(9) an advance directive, if there is one available.

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

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

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

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

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

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

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

(6) planned frequency and type of services initiated;

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

(8) clear progress notes on outcome of goals;

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

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

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

(1) room and board services;

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

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

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

(5) services performed by volunteers;

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

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

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(8) outreach services to potential recipients; and

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

History: *1Sp2001 c 9 art 9 s 40; 2002 c 379 art 1 s 113; 2005 c 165 art 1 s 3; 2009 c 79 art 7 s 16,17; 2009 c 167 s 12; 2011 c 86 s 14-16; 2014 c 312 art 29 s 7-10*

256B.0625 COVERED SERVICES.

Subdivision 1. **Inpatient hospital services.** Medical assistance covers inpatient hospital services. A second medical opinion is required prior to reimbursement for elective surgeries requiring a second opinion. The commissioner shall publish in the State Register a list of elective surgeries that require a second medical opinion prior to reimbursement, and the criteria and standards for deciding whether an elective surgery should require a second medical opinion. The list and the criteria and standards are not subject to the requirements of sections 14.001 to 14.69. The commissioner's decision whether a second medical opinion is required, made in accordance with rules governing that decision, is not subject to administrative appeal.

Subd. 1a. **Services provided in a hospital emergency room.** Medical assistance does not cover visits to a hospital emergency room that are not for emergency and emergency poststabilization care or urgent care, and does not pay for any services provided in a hospital emergency room that are not for emergency and emergency poststabilization care or urgent care.

Subd. 2. **Skilled and intermediate nursing care.** (a) Medical assistance covers skilled nursing home services and services of intermediate care facilities, including training and habilitation services, as defined in section 252.41, subdivision 3, for persons with developmental disabilities who are residing in intermediate care facilities for persons with developmental disabilities. Medical assistance must not be used to pay the costs of nursing care provided to a patient in a swing bed as defined in section 144.562, unless (1) the facility in which the swing bed is located is eligible as a sole community provider, as defined in Code of Federal Regulations, title 42, section 412.92, or the facility is a public hospital owned by a governmental entity with 15 or fewer licensed acute care beds; (2) the Centers for Medicare and Medicaid Services approves the necessary state plan amendments; (3) the patient was screened as provided by law; (4) the patient no longer requires acute care services; and (5) no nursing home beds are available within 25 miles of the facility. The commissioner shall exempt a facility from compliance with the sole community provider requirement in clause (1) if, as of January 1, 2004, the facility had an agreement with the commissioner to provide medical assistance swing bed services.

(b) Medical assistance also covers up to ten days of nursing care provided to a patient in a swing bed if: (1) the patient's physician certifies that the patient has a terminal illness or condition that is likely to result in death within 30 days and that moving the patient would not be in the best interests of the patient and patient's family; (2) no open nursing home beds are available within 25 miles of the facility; and (3) no open beds are available in any Medicare hospice program within 50 miles of the facility. The daily medical assistance payment for nursing care for the patient in the swing bed is the statewide average medical assistance skilled nursing care per diem as computed annually by the commissioner on July 1 of each year.

Subd. 2a. **Skilled nursing facility and hospice services for dual eligibles.** Medical assistance covers skilled nursing facility services for individuals eligible for both medical assistance and Medicare who have waived the Medicare skilled nursing facility room and board benefit and have enrolled in the Medicare hospice program. Medical assistance covers skilled nursing facility services regardless of whether an individual enrolled in the Medicare hospice program prior to, on, or after the date of the hospitalization that qualified the individual for Medicare skilled nursing facility services.

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Subd. 3. **Physicians' services.** (a) Medical assistance covers physicians' services.

(b) Rates paid for anesthesiology services provided by physicians shall be according to the formula utilized in the Medicare program and shall use a conversion factor "at percentile of calendar year set by legislature, "except that rates paid to physicians for the medical direction of a certified registered nurse anesthetist shall be the same as the rate paid to the certified registered nurse anesthetist under medical direction.

(c) Medical assistance does not cover physicians' services related to the provision of care related to a treatment reportable under section 144.7065, subdivision 2, clauses (1), (2), (3), and (5), and subdivision 7, clause (1).

(d) Medical assistance does not cover physicians' services related to the provision of care (1) for which hospital reimbursement is prohibited under section 256.969, subdivision 3b, paragraph (c), or (2) reportable under section 144.7065, subdivisions 2 to 7, if the physicians' services are billed by a physician who delivered care that contributed to or caused the adverse health care event or hospital-acquired condition.

(e) The payment limitations in this subdivision shall also apply to MinnesotaCare and general assistance medical care.

(f) A physician shall not bill a recipient of services for any payment disallowed under this subdivision.

Subd. 3a. **Sex reassignment surgery.** Sex reassignment surgery is not covered.

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

Subd. 3c. **Health Services Policy Committee.** (a) The commissioner, after receiving recommendations from professional physician associations, professional associations representing licensed nonphysician health care professionals, and consumer groups, shall establish a 13-member Health Services Policy Committee, which consists of 12 voting members and one nonvoting member. The Health Services Policy Committee shall advise the commissioner regarding health services pertaining to the administration of health care benefits covered under the medical assistance, general assistance medical care, and MinnesotaCare programs. The Health Services Policy Committee shall meet at least quarterly. The Health Services Policy Committee shall annually elect a physician chair from among its members, who shall work directly with the commissioner's medical director, to establish the agenda for each meeting. The Health Services Policy Committee shall also recommend criteria for verifying centers of excellence for specific aspects of medical care where a specific set of combined services, a volume of patients necessary to maintain a high level of competency, or a specific level of technical capacity is associated with improved health outcomes.

(b) The commissioner shall establish a dental subcommittee to operate under the Health Services Policy Committee. The dental subcommittee consists of general dentists, dental specialists, safety net providers,

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dental hygienists, health plan company and county and public health representatives, health researchers, consumers, and a designee of the commissioner of health. The dental subcommittee shall advise the commissioner regarding:

(1) the critical access dental program under section 256B.76, subdivision 4, including but not limited to criteria for designating and terminating critical access dental providers;

(2) any changes to the critical access dental provider program necessary to comply with program expenditure limits;

(3) dental coverage policy based on evidence, quality, continuity of care, and best practices;

(4) the development of dental delivery models; and

(5) dental services to be added or eliminated from subdivision 9, paragraph (b).

(c) The Health Services Policy Committee shall study approaches to making provider reimbursement under the medical assistance, MinnesotaCare, and general assistance medical care programs contingent on patient participation in a patient-centered decision-making process, and shall evaluate the impact of these approaches on health care quality, patient satisfaction, and health care costs. The committee shall present findings and recommendations to the commissioner and the legislative committees with jurisdiction over health care by January 15, 2010.

(d) The Health Services Policy Committee shall monitor and track the practice patterns of physicians providing services to medical assistance, MinnesotaCare, and general assistance medical care enrollees under fee-for-service, managed care, and county-based purchasing. The committee shall focus on services or specialties for which there is a high variation in utilization across physicians, or which are associated with high medical costs. The commissioner, based upon the findings of the committee, shall regularly notify physicians whose practice patterns indicate higher than average utilization or costs. Managed care and county-based purchasing plans shall provide the commissioner with utilization and cost data necessary to implement this paragraph, and the commissioner shall make this data available to the committee.

(e) The Health Services Policy Committee shall review caesarean section rates for the fee-for-service medical assistance population. The committee may develop best practices policies related to the minimization of caesarean sections, including but not limited to standards and guidelines for health care providers and health care facilities.

Subd. 3d. **Health Services Policy Committee members.** The Health Services Policy Committee consists of:

(1) seven voting members who are licensed physicians actively engaged in the practice of medicine in Minnesota, one of whom must be actively engaged in the treatment of persons with mental illness, and three of whom must represent health plans currently under contract to serve medical assistance recipients;

(2) two voting members who are physician specialists actively practicing their specialty in Minnesota;

(3) two voting members who are nonphysician health care professionals licensed or registered in their profession and actively engaged in their practice of their profession in Minnesota;

(4) one consumer who shall serve as a voting member; and

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(5) the commissioner's medical director who shall serve as a nonvoting member.

Members of the Health Services Policy Committee shall not be employed by the Department of Human Services, except for the medical director.

Subd. 3e. **Health Services Policy Committee terms and compensation.** Committee members shall serve staggered three-year terms, with one-third of the voting members' terms expiring annually. Members may be reappointed by the commissioner. The commissioner may require more frequent Health Services Policy Committee meetings as needed. An honorarium of $200 per meeting and reimbursement for mileage and parking shall be paid to each committee member in attendance except the medical director. The Health Services Policy Committee does not expire as provided in section 15.059, subdivision 6.

Subd. 3f. **Circumcision.** Circumcision is not covered, unless the procedure is medically necessary.

Subd. 3g. **Evidence-based childbirth program.** (a) The commissioner shall implement a program to reduce the number of elective inductions of labor prior to 39 weeks' gestation. In this subdivision, the term "elective induction of labor" means the use of artificial means to stimulate labor in a woman without the presence of a medical condition affecting the woman or the child that makes the onset of labor a medical necessity. The program must promote the implementation of policies within hospitals providing services to recipients of medical assistance or MinnesotaCare that prohibit the use of elective inductions prior to 39 weeks' gestation, and adherence to such policies by the attending providers.

(b) For all births covered by medical assistance or MinnesotaCare on or after January 1, 2012, a payment for professional services associated with the delivery of a child in a hospital must not be made unless the provider has submitted information about the nature of the labor and delivery including any induction of labor that was performed in conjunction with that specific birth. The information must be on a form prescribed by the commissioner.

(c) The requirements in paragraph (b) must not apply to deliveries performed at a hospital that has policies and processes in place that have been approved by the commissioner which prohibit elective inductions prior to 39 weeks' gestation. A process for review of hospital induction policies must be established by the commissioner and review of policies must occur at the discretion of the commissioner. The commissioner's decision to approve or rescind approval must include verification and review of items including, but not limited to:

(1) policies that prohibit use of elective inductions for gestation less than 39 weeks;

(2) policies that encourage providers to document and communicate with patients a final expected date of delivery by 20 weeks' gestation that includes data from ultrasound measurements as applicable;

(3) policies that encourage patient education regarding elective inductions, and requires documentation of the processes used to educate patients;

(4) ongoing quality improvement review as determined by the commissioner; and

(5) any data that has been collected by the commissioner.

(d) All hospitals must report annually to the commissioner induction information for all births that were covered by medical assistance or MinnesotaCare in a format and manner to be established by the commissioner.

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(e) The commissioner at any time may choose not to implement or may discontinue any or all aspects of the program if the commissioner is able to determine that hospitals representing at least 90 percent of births covered by medical assistance or MinnesotaCare have approved policies in place.

(f) The commissioner of human services may discontinue the evidence-based childbirth program and shall discontinue all affiliated reporting requirements established under this subdivision once the commissioner determines that hospitals representing at least 90 percent of births covered by medical assistance or MinnesotaCare have approved policies and processes in place that prohibit elective inductions prior to 39 weeks' gestation.

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

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

Subd. 5. **Community mental health center services.** Medical assistance covers community mental health center services provided by a community mental health center that meets the requirements in paragraphs (a) to (j).

(a) The provider is licensed under Minnesota Rules, parts 9520.0750 to 9520.0870.

(b) The provider provides mental health services under the clinical supervision of a mental health professional who is licensed for independent practice at the doctoral level or by a board-certified psychiatrist or a psychiatrist who is eligible for board certification. Clinical supervision has the meaning given in Minnesota Rules, part 9505.0323, subpart 1, item F.

(c) The provider must be a private nonprofit corporation or a governmental agency and have a community board of directors as specified by section 245.66.

(d) The provider must have a sliding fee scale that meets the requirements in section 245.481, and agree to serve within the limits of its capacity all individuals residing in its service delivery area.

(e) At a minimum, the provider must provide the following outpatient mental health services: diagnostic assessment; explanation of findings; family, group, and individual psychotherapy, including crisis

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intervention psychotherapy services, multiple family group psychotherapy, psychological testing, and medication management. In addition, the provider must provide or be capable of providing upon request of the local mental health authority day treatment services and professional home-based mental health services. The provider must have the capacity to provide such services to specialized populations such as the elderly, families with children, persons who are seriously and persistently mentally ill, and children who are seriously emotionally disturbed.

(f) The provider must be capable of providing the services specified in paragraph (e) to individuals who are diagnosed with both mental illness or emotional disturbance, and chemical dependency, and to individuals dually diagnosed with a mental illness or emotional disturbance and developmental disability.

(g) The provider must provide 24-hour emergency care services or demonstrate the capacity to assist recipients in need of such services to access such services on a 24-hour basis.

(h) The provider must have a contract with the local mental health authority to provide one or more of the services specified in paragraph (e).

(i) The provider must agree, upon request of the local mental health authority, to enter into a contract with the county to provide mental health services not reimbursable under the medical assistance program.

(j) The provider may not be enrolled with the medical assistance program as both a hospital and a community mental health center. The community mental health center's administrative, organizational, and financial structure must be separate and distinct from that of the hospital.

Subd. 5a. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5b. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5c. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5d. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5e. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5f. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5g. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5h. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5i. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5j. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5k. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5l. **Intensive mental health outpatient treatment.** Medical assistance covers intensive mental health outpatient treatment for dialectical behavioral therapy for adults. The commissioner shall establish:

(1) certification procedures to ensure that providers of these services are qualified; and

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(2) treatment protocols including required service components and criteria for admission, continued treatment, and discharge.

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

Subd. 6a. **Home health services.** Home health services are those services specified in Minnesota Rules, part 9505.0295 and sections 256B.0651 and 256B.0653. 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 authorized skilled nurse visits for less than 90 days for a resident at an intermediate care facility for persons with developmental disabilities, 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 sections 256B.0651 to 256B.0653.

Subd. 7. **Home care nursing.** Medical assistance covers home care nursing services in a recipient's home. Recipients who are authorized to receive home care nursing services in their home may use approved hours outside of the home during hours when normal life activities take them outside of their home. To use home care nursing services at school, the recipient or responsible party must provide written authorization in the care plan identifying the chosen provider and the daily amount of services to be used at school. Medical assistance does not cover home care nursing services for residents of a hospital, nursing facility, intermediate care facility, or a health care facility licensed by the commissioner of health, except as authorized in section 256B.64 for ventilator-dependent recipients in hospitals or unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the home care nursing services or forgoes the facility per diem for the leave days that home care nursing services are used. Total hours of service and payment allowed for services outside the home cannot exceed that which is otherwise allowed in an in-home setting according to sections 256B.0651 and 256B.0654 . All home care nursing services must be provided according to the limits established under sections 256B.0651, 256B.0653, and 256B.0654. Home care nursing services may not be reimbursed if the nurse is the family foster care provider of a recipient who is under age 18, unless allowed under section 256B.0654, subdivision 4.

Subd. 8. **Physical therapy.** (a) Medical assistance covers physical therapy and related services. Specialized maintenance therapy is covered for recipients age 20 and under.

(b) 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.** (a) Medical assistance covers occupational therapy and related services. Specialized maintenance therapy is covered for recipients age 20 and under.

(b) 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.

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Subd. 8b. **Speech-language pathology and audiology services.** (a) Medical assistance covers speech-language pathology and related services. Specialized maintenance therapy is covered for recipients age 20 and under.

(b) Medical assistance covers audiology services and related services. Services provided by a person who has been issued a temporary registration under section 148.5161 shall be reimbursed at the same rate as services performed by a speech-language pathologist or audiologist as long as the requirements of section 148.5161, subdivision 3, are met.

Subd. 8c. **Care management; rehabilitation services.** (a) A care management approach for authorization of rehabilitation services described in subdivisions 8, 8a, and 8b shall be instituted. 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 six 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.

(b) The commissioner shall implement an expedited five-day turnaround time to review authorization requests for recipients who need emergency rehabilitation services.

Subd. 8d. **Home infusion therapy services.** Home infusion therapy services provided by home infusion therapy pharmacies must be paid the lower of the submitted charge or the combined payment rates for component services typically provided.

Subd. 8e. **Chiropractic services.** Payment for chiropractic services is limited to one annual evaluation and 24 visits per year unless prior authorization of a greater number of visits is obtained.

Subd. 8f. **Acupuncture services.** Medical assistance covers acupuncture, as defined in section 147B.01, subdivision 3, only when provided by a licensed acupuncturist or by another Minnesota licensed practitioner for whom acupuncture is within the practitioner's scope of practice and who has specific acupuncture training or credentialing.

Subd. 9. **Dental services.** (a) Medical assistance covers dental services.

(b) Medical assistance dental coverage for nonpregnant adults is limited to the following services:

(1) comprehensive exams, limited to once every five years;

(2) periodic exams, limited to one per year;

(3) limited exams;

(4) bitewing x-rays, limited to one per year;

(5) periapical x-rays;

(6) panoramic x-rays, limited to one every five years except (1) when medically necessary for the diagnosis and follow-up of oral and maxillofacial pathology and trauma or (2) once every two years for patients who cannot cooperate for intraoral film due to a developmental disability or medical condition that does not allow for intraoral film placement;

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(7) prophylaxis, limited to one per year;

(8) application of fluoride varnish, limited to one per year;

(9) posterior fillings, all at the amalgam rate;

(10) anterior fillings;

(11) endodontics, limited to root canals on the anterior and premolars only;

(12) removable prostheses, each dental arch limited to one every six years;

(13) oral surgery, limited to extractions, biopsies, and incision and drainage of abscesses;

(14) palliative treatment and sedative fillings for relief of pain; and

(15) full-mouth debridement, limited to one every five years.

(c) In addition to the services specified in paragraph (b), medical assistance covers the following services for adults, if provided in an outpatient hospital setting or freestanding ambulatory surgical center as part of outpatient dental surgery:

(1) periodontics, limited to periodontal scaling and root planing once every two years;

(2) general anesthesia; and

(3) full-mouth survey once every five years.

(d) Medical assistance covers medically necessary dental services for children and pregnant women. The following guidelines apply:

(1) posterior fillings are paid at the amalgam rate;

(2) application of sealants are covered once every five years per permanent molar for children only;

(3) application of fluoride varnish is covered once every six months; and

(4) orthodontia is eligible for coverage for children only.

(e) In addition to the services specified in paragraphs (b) and (c), medical assistance covers the following services for adults:

(1) house calls or extended care facility calls for on-site delivery of covered services;

(2) behavioral management when additional staff time is required to accommodate behavioral challenges and sedation is not used;

(3) oral or IV sedation, if the covered dental service cannot be performed safely without it or would otherwise require the service to be performed under general anesthesia in a hospital or surgical center; and

(4) prophylaxis, in accordance with an appropriate individualized treatment plan, but no more than four times per year.

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(f) The commissioner shall not require prior authorization for the services included in paragraph (e), clauses (1) to (3), and shall prohibit managed care and county-based purchasing plans from requiring prior authorization for the services included in paragraph (e), clauses (1) to (3), when provided under sections 256B.69, 256B.692, and 256L.12.

Subd. 9a. **Volunteer dental services.** (a) A dentist not already enrolled as a medical assistance provider who is providing volunteer dental services for an enrolled medical assistance dental provider that is a nonprofit entity or government owned and not receiving payment for the services provided shall complete and submit a volunteer agreement form developed by the commissioner. The volunteer agreement shall be used to enroll the dentist in medical assistance only for the purpose of providing volunteer dental services. The volunteer agreement must specify that a volunteer dentist:

(1) will not be listed in the Minnesota health care programs provider directory;

(2) will not receive payment for the services the volunteer dentist provides to Minnesota health care program clients; and

(3) is not required to serve Minnesota health care program clients when providing nonvolunteer services in a private practice.

(b) A volunteer dentist enrolled under this subdivision as a fee-for-service provider shall not otherwise be enrolled in or receive payments from Minnesota health care programs as a fee-for-service provider.

(c) The volunteer dentist shall be notified by the dental provider for which they are providing services that medical assistance is being billed for the volunteer services provided.

Subd. 10. **Laboratory and x-ray services.** Medical assistance covers laboratory and x-ray services.

Subd. 11. **Nurse anesthetist services.** Medical assistance covers nurse anesthetist services. Rates paid for anesthesiology services provided by a certified registered nurse anesthetist under the direction of a physician shall be according to the formula utilized in the Medicare program and shall use the conversion factor that is used by the Medicare program. Rates paid for anesthesiology services provided by a certified registered nurse anesthetist who is not directed by a physician shall be the same rate as paid under subdivision 3, paragraph (b).

Subd. 12. **Eyeglasses, dentures, and prosthetic devices.** Medical assistance covers eyeglasses, dentures, and prosthetic devices if prescribed by a licensed practitioner.

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, physician assistant, 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.

(b) The dispensed quantity of a prescription drug must not exceed a 34-day supply, unless authorized by the commissioner.

(c) For the purpose of this subdivision and subdivision 13d, an "active pharmaceutical ingredient" is defined as a substance that is represented for use in a drug and when used in the manufacturing, processing, or packaging of a drug becomes an active ingredient of the drug product. An "excipient" is defined as an

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inert substance used as a diluent or vehicle for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and excipients which are included in the medical assistance formulary. Medical assistance covers selected active pharmaceutical ingredients and excipients used in compounded prescriptions when the compounded combination is specifically approved by the commissioner or when a commercially available product:

(1) is not a therapeutic option for the patient;

(2) does not exist in the same combination of active ingredients in the same strengths as the compounded prescription; and

(3) cannot be used in place of the active pharmaceutical ingredient in the compounded prescription.

(d) Medical assistance covers the following over-the-counter drugs when prescribed by a licensed practitioner or by a licensed pharmacist who meets standards established by the commissioner, in consultation with the board of pharmacy: 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 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. A pharmacist may prescribe over-the-counter medications as provided under this paragraph for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter drugs under this paragraph, licensed pharmacists must consult with the recipient to determine necessity, provide drug counseling, review drug therapy for potential adverse interactions, and make referrals as needed to other health care professionals. Over-the-counter medications must be dispensed in a quantity that is the lower of: (1) the number of dosage units contained in the manufacturer's original package; and (2) the number of dosage units required to complete the patient's course of therapy.

(e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible for drug coverage as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these individuals, medical assistance may cover drugs from the drug classes listed in United States Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall not be covered.

(f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B covered entities and ambulatory pharmacies under common ownership of the 340B covered entity. Medical assistance does not cover drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies.

Subd. 13a. [Repealed, 2007 c 133 art 2 s 13]

Subd. 13b. [Repealed, 1997 c 203 art 4 s 73]

Subd. 13c. **Formulary Committee.** The commissioner, after receiving recommendations from professional medical associations and professional pharmacy associations, and consumer groups shall designate a Formulary Committee to carry out duties as described in subdivisions 13 to 13g. The Formulary Committee shall be comprised of four licensed physicians actively engaged in the practice of medicine in Minnesota one of whom must be actively engaged in the treatment of persons with mental illness; at least three licensed

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pharmacists actively engaged in the practice of pharmacy in Minnesota; and one consumer representative; the remainder to be made up of health care professionals who are licensed in their field and have recognized knowledge in the clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs. Members of the Formulary Committee shall not be employed by the Department of Human Services, but the committee shall be staffed by an employee of the department who shall serve as an ex officio, nonvoting member of the committee. The department's medical director shall also serve as an ex officio, nonvoting member for the committee. Committee members shall serve three-year terms and may be reappointed by the commissioner. The Formulary Committee shall meet at least twice per year. The commissioner may require more frequent Formulary Committee meetings as needed. An honorarium of $100 per meeting and reimbursement for mileage shall be paid to each committee member in attendance. The Formulary Committee expires June 30, 2018.

Subd. 13d. **Drug formulary.** (a) 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.

(b) The formulary shall not include:

(1) drugs, active pharmaceutical ingredients, or products for which there is no federal funding;

(2) over-the-counter drugs, except as provided in subdivision 13;

(3) drugs or active pharmaceutical ingredients used for weight loss, except that medically necessary lipase inhibitors may be covered for a recipient with type II diabetes;

(4) drugs or active pharmaceutical ingredients when used for the treatment of impotence or erectile dysfunction;

(5) drugs or active pharmaceutical ingredients for which medical value has not been established;

(6) 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; and

(7) medical cannabis as defined in section 152.22, subdivision 6.

(c) If a single-source drug used by at least two percent of the fee-for-service medical assistance recipients is removed from the formulary due to the failure of the manufacturer to sign a rebate agreement with the Department of Health and Human Services, the commissioner shall notify prescribing practitioners within 30 days of receiving notification from the Centers for Medicare and Medicaid Services (CMS) that a rebate agreement was not signed.

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs or the maximum allowable cost by the commissioner plus the fixed dispensing fee; or the usual and customary price charged to the public. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The pharmacy dispensing fee shall be $3.65, except that the dispensing fee for intravenous solutions which must be compounded by the pharmacist shall be $8 per bag, $14 per bag for cancer chemotherapy products, and $30 per bag for total parenteral nutritional products dispensed in one liter quantities, or $44 per bag for total parenteral nutritional products dispensed in quantities greater than one

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liter. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. The actual acquisition cost of a drug shall be estimated by the commissioner at wholesale acquisition cost plus four percent for independently owned pharmacies located in a designated rural area within Minnesota, and at wholesale acquisition cost plus two percent for all other pharmacies. A pharmacy is "independently owned" if it is one of four or fewer pharmacies under the same ownership nationally. A "designated rural area" means an area defined as a small rural area or isolated rural area according to the four-category classification of the Rural Urban Commuting Area system developed for the United States Health Resources and Services Administration. Effective January 1, 2014, the actual acquisition cost of a drug acquired through the federal 340B Drug Pricing Program shall be estimated by the commissioner at wholesale acquisition cost minus 40 percent. Wholesale acquisition cost is defined as the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates, or reductions in price, for the most recent month for which information is available, as reported in wholesale price guides or other publications of drug or biological pricing data. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, the maximum amount paid by other third-party payors in this state who have maximum allowable cost programs. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) 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. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply.

(c) Whenever a maximum allowable cost has been set for a multisource drug, payment shall be the lower of the usual and customary price charged to the public or the maximum allowable cost established by the commissioner unless prior authorization for the brand name product has been granted according to the criteria established by the Drug Formulary Committee as required by subdivision 13f, paragraph (a), and the prescriber has indicated "dispense as written" on the prescription in a manner consistent with section 151.21, subdivision 2.

(d) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider, 106 percent of the average sales price as determined by the United States Department of Health and Human Services pursuant to title XVIII, section 1847a of the federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner. If average sales price is unavailable, the amount of payment must be lower of the usual and customary cost submitted by the provider, the wholesale acquisition cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner. Effective January 1, 2014, the commissioner shall discount the payment rate for drugs obtained through the federal 340B Drug Pricing Program by 20 percent. The payment for drugs administered in an outpatient setting shall be made to the administering facility or practitioner. A retail or specialty pharmacy dispensing a drug for administration in an outpatient setting is not eligible for direct reimbursement.

(e) The commissioner may negotiate lower reimbursement rates for specialty pharmacy products than the rates specified in paragraph (a). The commissioner may require individuals enrolled in the health care

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programs administered by the department to obtain specialty pharmacy products from providers with whom the commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are defined as those used by a small number of recipients or recipients with complex and chronic diseases that require expensive and challenging drug regimens. Examples of these conditions include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of cancer. Specialty pharmaceutical products include injectable and infusion therapies, biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies that require complex care. The commissioner shall consult with the formulary committee to develop a list of specialty pharmacy products subject to this paragraph. In consulting with the formulary committee in developing this list, the commissioner shall take into consideration the population served by specialty pharmacy products, the current delivery system and standard of care in the state, and access to care issues. The commissioner shall have the discretion to adjust the reimbursement rate to prevent access to care issues.

(f) Home infusion therapy services provided by home infusion therapy pharmacies must be paid at rates according to subdivision 8d.

Subd. 13f. **Prior authorization.** (a) The Formulary Committee shall review and recommend drugs which require prior authorization. The Formulary Committee shall establish general criteria to be used for the prior authorization of brand-name drugs for which generically equivalent drugs are available, but the committee is not required to review each brand-name drug for which a generically equivalent drug is available.

(b) Prior authorization may be required by the commissioner before certain formulary drugs are eligible for payment. The Formulary Committee may recommend drugs for prior authorization directly to the commissioner. The commissioner may also request that the Formulary Committee review a drug for prior authorization. Before the commissioner may require prior authorization for a drug:

(1) the commissioner must provide information to the Formulary Committee on the impact that placing the drug on prior authorization may have on the quality of patient care and on program costs, information regarding whether the drug is subject to clinical abuse or misuse, and relevant data from the state Medicaid program if such data is available;

(2) the Formulary Committee must review the drug, taking into account medical and clinical data and the information provided by the commissioner; and

(3) the Formulary Committee must hold a public forum and receive public comment for an additional 15 days.

The commissioner must provide a 15-day notice period before implementing the prior authorization.

(c) Except as provided in subdivision 13j, prior authorization shall not be required or utilized for any atypical antipsychotic drug prescribed for the treatment of mental illness if:

(1) there is no generically equivalent drug available; and

(2) the drug was initially prescribed for the recipient prior to July 1, 2003; or

(3) the drug is part of the recipient's current course of treatment.

This paragraph applies to any multistate preferred drug list or supplemental drug rebate program established or administered by the commissioner. Prior authorization shall automatically be granted for 60 days for

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brand name drugs prescribed for treatment of mental illness within 60 days of when a generically equivalent drug becomes available, provided that the brand name drug was part of the recipient's course of treatment at the time the generically equivalent drug became available.

(d) Prior authorization shall not be required or utilized for any antihemophilic factor drug prescribed for the treatment of hemophilia and blood disorders where there is no generically equivalent drug available if the prior authorization is used in conjunction with any supplemental drug rebate program or multistate preferred drug list established or administered by the commissioner.

(e) The commissioner may require prior authorization for brand name drugs whenever a generically equivalent product is available, even if the prescriber specifically indicates "dispense as written-brand necessary" on the prescription as required by section 151.21, subdivision 2.

(f) Notwithstanding this subdivision, the commissioner may automatically require prior authorization, for a period not to exceed 180 days, for any drug that is approved by the United States Food and Drug Administration on or after July 1, 2005. The 180-day period begins no later than the first day that a drug is available for shipment to pharmacies within the state. The Formulary Committee shall recommend to the commissioner general criteria to be used for the prior authorization of the drugs, but the committee is not required to review each individual drug. In order to continue prior authorizations for a drug after the 180-day period has expired, the commissioner must follow the provisions of this subdivision.

Subd. 13g. **Preferred drug list.** (a) The commissioner shall adopt and implement a preferred drug list by January 1, 2004. The commissioner may enter into a contract with a vendor for the purpose of participating in a preferred drug list and supplemental rebate program. The commissioner shall ensure that any contract meets all federal requirements and maximizes federal financial participation. The commissioner shall publish the preferred drug list annually in the State Register and shall maintain an accurate and up-to-date list on the agency Web site.

(b) The commissioner may add to, delete from, and otherwise modify the preferred drug list, after consulting with the Formulary Committee and appropriate medical specialists and providing public notice and the opportunity for public comment.

(c) The commissioner shall adopt and administer the preferred drug list as part of the administration of the supplemental drug rebate program. Reimbursement for prescription drugs not on the preferred drug list may be subject to prior authorization.

(d) For purposes of this subdivision, "preferred drug list" means a list of prescription drugs within designated therapeutic classes selected by the commissioner, for which prior authorization based on the identity of the drug or class is not required.

(e) The commissioner shall seek any federal waivers or approvals necessary to implement this subdivision.

Subd. 13h. **Medication therapy management services.** (a) Medical assistance and general assistance medical care cover medication therapy management services for a recipient taking three or more prescriptions to treat or prevent one or more chronic medical conditions; a recipient with a drug therapy problem that is identified by the commissioner or identified by a pharmacist and approved by the commissioner; or prior authorized by the commissioner that has resulted or is likely to result in significant nondrug program costs. The commissioner may cover medical therapy management services under MinnesotaCare if the commissioner determines this is cost-effective. For purposes of this subdivision, "medication therapy

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management" means the provision of the following pharmaceutical care services by a licensed pharmacist to optimize the therapeutic outcomes of the patient's medications:

(1) performing or obtaining necessary assessments of the patient's health status;

(2) formulating a medication treatment plan;

(3) monitoring and evaluating the patient's response to therapy, including safety and effectiveness;

(4) performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events;

(5) documenting the care delivered and communicating essential information to the patient's other primary care providers;

(6) providing verbal education and training designed to enhance patient understanding and appropriate use of the patient's medications;

(7) providing information, support services, and resources designed to enhance patient adherence with the patient's therapeutic regimens; and

(8) coordinating and integrating medication therapy management services within the broader health care management services being provided to the patient.

Nothing in this subdivision shall be construed to expand or modify the scope of practice of the pharmacist as defined in section 151.01, subdivision 27.

(b) To be eligible for reimbursement for services under this subdivision, a pharmacist must meet the following requirements:

(1) have a valid license issued by the Board of Pharmacy of the state in which the medication therapy management service is being performed;

(2) have graduated from an accredited college of pharmacy on or after May 1996, or completed a structured and comprehensive education program approved by the Board of Pharmacy and the American Council of Pharmaceutical Education for the provision and documentation of pharmaceutical care management services that has both clinical and didactic elements;

(3) be practicing in an ambulatory care setting as part of a multidisciplinary team or have developed a structured patient care process that is offered in a private or semiprivate patient care area that is separate from the commercial business that also occurs in the setting, or in home settings, including long-term care settings, group homes, and facilities providing assisted living services, but excluding skilled nursing facilities; and

(4) make use of an electronic patient record system that meets state standards.

(c) For purposes of reimbursement for medication therapy management services, the commissioner may enroll individual pharmacists as medical assistance and general assistance medical care providers. The commissioner may also establish contact requirements between the pharmacist and recipient, including limiting the number of reimbursable consultations per recipient.

(d) If there are no pharmacists who meet the requirements of paragraph (b) practicing within a reasonable geographic distance of the patient, a pharmacist who meets the requirements may provide the services via

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two-way interactive video. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to the services provided. To qualify for reimbursement under this paragraph, the pharmacist providing the services must meet the requirements of paragraph (b), and must be located within an ambulatory care setting approved by the commissioner. The patient must also be located within an ambulatory care setting approved by the commissioner. Services provided under this paragraph may not be transmitted into the patient's residence.

(e) The commissioner shall establish a pilot project for an intensive medication therapy management program for patients identified by the commissioner with multiple chronic conditions and a high number of medications who are at high risk of preventable hospitalizations, emergency room use, medication complications, and suboptimal treatment outcomes due to medication-related problems. For purposes of the pilot project, medication therapy management services may be provided in a patient's home or community setting, in addition to other authorized settings. The commissioner may waive existing payment policies and establish special payment rates for the pilot project. The pilot project must be designed to produce a net savings to the state compared to the estimated costs that would otherwise be incurred for similar patients without the program. The pilot project must begin by January 1, 2010, and end June 30, 2012.

Subd. 13i. **Drug Utilization Review Board; report.** (a) A nine-member Drug Utilization Review Board is established. The board must be comprised of at least three but no more than four licensed physicians actively engaged in the practice of medicine in Minnesota; at least three licensed pharmacists actively engaged in the practice of pharmacy in Minnesota; and one consumer representative. The remainder must be made up of health care professionals who are licensed in their field and have recognized knowledge in the clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs. Members of the board must be appointed by the commissioner, shall serve three-year terms, and may be reappointed by the commissioner. The board shall annually elect a chair from among its members.

(b) The board must be staffed by an employee of the department who shall serve as an ex officio nonvoting member of the board.

(c) The commissioner shall, with the advice of the board:

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

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

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

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

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

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

(7) establish and implement an ongoing process to:

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(i) receive public comment regarding drug utilization review criteria and standards; and

(ii) consider the comments along with other scientific and clinical information in order to revise criteria and standards on a timely basis; and

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

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

(e) The board shall report to the commissioner annually on the date the drug utilization review annual report is due to the Centers for Medicare and Medicaid Services. This report must cover the preceding federal fiscal year. The commissioner shall make the report available to the public upon request. The report must include information on the activities of the board and the program; the effectiveness of implemented interventions; administrative costs; and any fiscal impact resulting from the program. An honorarium of $100 per meeting and reimbursement for mileage must be paid to each board member in attendance.

(f) This subdivision is exempt from the provisions of section 15.059.

Subd. 13j. **Antipsychotic and attention deficit disorder and attention deficit hyperactivity disorder medications.** (a) The commissioner, in consultation with the Drug Utilization Review Board established in subdivision 13i and actively practicing pediatric mental health professionals, must:

(1) identify recommended pediatric dose ranges for atypical antipsychotic drugs and drugs used for attention deficit disorder or attention deficit hyperactivity disorder based on available medical, clinical, and safety data and research. The commissioner shall periodically review the list of medications and pediatric dose ranges and update the medications and doses listed as needed after consultation with the Drug Utilization Review Board;

(2) identify situations where a collaborative psychiatric consultation and prior authorization should be required before the initiation or continuation of drug therapy in pediatric patients including, but not limited to, high-dose regimens, off-label use of prescription medication, a patient's young age, and lack of coordination among multiple prescribing providers; and

(3) track prescriptive practices and the use of psychotropic medications in children with the goal of reducing the use of medication, where appropriate.

(b) Effective July 1, 2011, the commissioner shall require prior authorization and a collaborative psychiatric consultation before an atypical antipsychotic and attention deficit disorder and attention deficit hyperactivity disorder medication meeting the criteria identified in paragraph (a), clause (2), is eligible for payment. A collaborative psychiatric consultation must be completed before the identified medications are eligible for payment unless:

(1) the patient has already been stabilized on the medication regimen; or

(2) the prescriber indicates that the child is in crisis.

If clause (1) or (2) applies, the collaborative psychiatric consultation must be completed within 90 days for payment to continue.

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(c) For purposes of this subdivision, a collaborative psychiatric consultation must meet the criteria described in section 245.4862, subdivision 4.

Subd. 14. **Diagnostic, screening, and preventive services.** (a) Medical assistance covers diagnostic, screening, and preventive services.

(b) "Preventive services" include services related to pregnancy, including:

(1) services for those conditions which may complicate a pregnancy and which may be available to a pregnant woman determined to be at risk of poor pregnancy outcome;

(2) prenatal HIV risk assessment, education, counseling, and testing; and

(3) alcohol abuse assessment, education, and counseling on the effects of alcohol usage while pregnant. Preventive services available to a woman at risk of poor pregnancy outcome may differ in an amount, duration, or scope from those available to other individuals eligible for medical assistance.

(c) "Screening services" include, but are not limited to, blood lead tests.

(d) The commissioner shall encourage, at the time of the child and teen checkup or at an episodic care visit, the primary care health care provider to perform primary caries preventive services. Primary caries preventive services include, at a minimum:

(1) a general visual examination of the child's mouth without using probes or other dental equipment or taking radiographs;

(2) a risk assessment using the factors established by the American Academies of Pediatrics and Pediatric Dentistry; and

(3) the application of a fluoride varnish beginning at age one to those children assessed by the provider as being high risk in accordance with best practices as defined by the Department of Human Services. The provider must obtain parental or legal guardian consent before a fluoride varnish is applied to a minor child's teeth.

At each checkup, if primary caries preventive services are provided, the provider must provide to the child's parent or legal guardian: information on caries etiology and prevention; and information on the importance of finding a dental home for their child by the age of one. The provider must also advise the parent or legal guardian to contact the child's managed care plan or the Department of Human Services in order to secure a dental appointment with a dentist. The provider must indicate in the child's medical record that the parent or legal guardian was provided with this information and document any primary caries prevention services provided to the child.

Subd. 15. **Health plan premiums and co-payments.** (a) Medical assistance covers health care prepayment plan premiums, insurance premiums, and co-payments if determined to be cost-effective by the commissioner. For purposes of obtaining Medicare Part A and Part B, and co-payments, expenditures may be made even if federal funding is not available.

(b) Effective for all premiums due on or after June 30, 1997, medical assistance does not cover premiums that a recipient is required to pay under a qualified or Medicare supplement plan issued by the Minnesota Comprehensive Health Association. Medical assistance shall continue to cover premiums for recipients who

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are covered under a plan issued by the Minnesota Comprehensive Health Association on June 30, 1997, for a period of six months following receipt of the notice of termination or until December 31, 1997, whichever is later.

Subd. 16. **Abortion services.** Medical assistance covers abortion services, but only if one of the following conditions is met:

(a) The abortion is a medical necessity. "Medical necessity" means (1) the signed written statement of two physicians indicating the abortion is medically necessary to prevent the death of the mother, and (2) the patient has given her consent to the abortion in writing unless the patient is physically or legally incapable of providing informed consent to the procedure, in which case consent will be given as otherwise provided by law;

(b) The pregnancy is the result of criminal sexual conduct as defined in section 609.342, clauses (c), (d), (e)(i), and (f), and the incident is reported within 48 hours after the incident occurs to a valid law enforcement agency for investigation, unless the victim is physically unable to report the criminal sexual conduct, in which case the report shall be made within 48 hours after the victim becomes physically able to report the criminal sexual conduct; or

(c) The pregnancy is the result of incest, but only if the incident and relative are reported to a valid law enforcement agency for investigation prior to the abortion.

[See Note.]

Subd. 17. **Transportation costs.** (a) "Nonemergency medical transportation service" means motor vehicle transportation provided by a public or private person that serves Minnesota health care program beneficiaries who do not require emergency ambulance service, as defined in section 144E.001, subdivision 3, to obtain covered medical services. Nonemergency medical transportation service includes, but is not limited to, special transportation service, defined in section 174.29, subdivision 1.

(b) Medical assistance covers medical transportation costs incurred solely for obtaining emergency medical care or transportation costs incurred by eligible persons in obtaining emergency or nonemergency medical care when paid directly to an ambulance company, common carrier, or other recognized providers of transportation services. Medical transportation must be provided by:

(1) nonemergency medical transportation providers who meet the requirements of this subdivision;

(2) ambulances, as defined in section 144E.001, subdivision 2;

(3) taxicabs and public transit, as defined in section 174.22, subdivision 7; or

(4) not-for-hire vehicles, including volunteer drivers.

(c) Medical assistance covers nonemergency medical transportation provided by nonemergency medical transportation providers enrolled in the Minnesota health care programs. All nonemergency medical transportation providers must comply with the operating standards for special transportation service as defined in sections 174.29 to 174.30 and Minnesota Rules, chapter 8840, and in consultation with the Minnesota Department of Transportation. All nonemergency medical transportation providers shall bill for nonemergency medical transportation services in accordance with Minnesota health care programs criteria. Publicly operated transit systems, volunteers, and not-for-hire vehicles are exempt from the requirements outlined in this paragraph.

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(d) The administrative agency of nonemergency medical transportation must:

(1) adhere to the policies defined by the commissioner in consultation with the Nonemergency Medical Transportation Advisory Committee;

(2) pay nonemergency medical transportation providers for services provided to Minnesota health care programs beneficiaries to obtain covered medical services;

(3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled trips, and number of trips by mode; and

(4) by July 1, 2016, in accordance with subdivision 18e, utilize a Web-based single administrative structure assessment tool that meets the technical requirements established by the commissioner, reconciles trip information with claims being submitted by providers, and ensures prompt payment for nonemergency medical transportation services.

(e) Until the commissioner implements the single administrative structure and delivery system under subdivision 18e, clients shall obtain their level-of-service certificate from the commissioner or an entity approved by the commissioner that does not dispatch rides for clients using modes under paragraph (h), clauses (4), (5), (6), and (7).

(f) The commissioner may use an order by the recipient's attending physician or a medical or mental health professional to certify that the recipient requires nonemergency medical transportation services. Nonemergency medical transportation providers shall perform driver-assisted services for eligible individuals, when appropriate. Driver-assisted service includes passenger pickup at and return to the individual's residence or place of business, assistance with admittance of the individual to the medical facility, and assistance in passenger securement or in securing of wheelchairs or stretchers in the vehicle. Nonemergency medical transportation providers must have trip logs, which include pickup and drop-off times, signed by the medical provider or client attesting mileage traveled to obtain covered medical services, whichever is deemed most appropriate. Nonemergency medical transportation providers may not bill for separate base rates for the continuation of a trip beyond the original destination. Nonemergency medical transportation providers must take clients to the health care provider, using the most direct route, and must not exceed 30 miles for a trip to a primary care provider or 60 miles for a trip to a specialty care provider, unless the client receives authorization from the local agency. The minimum medical assistance reimbursement rates for special transportation services are:

(1)(i) $17 for the base rate and $1.35 per mile for special transportation services to eligible persons who need a wheelchair-accessible van;

(ii) $11.50 for the base rate and $1.30 per mile for special transportation services to eligible persons who do not need a wheelchair-accessible van; and

(iii) $60 for the base rate and $2.40 per mile, and an attendant rate of $9 per trip, for special transportation services to eligible persons who need a stretcher-accessible vehicle; and

(2) clients requesting client mileage reimbursement must sign the trip log attesting mileage traveled to obtain covered medical services.

(g) The covered modes of nonemergency medical transportation include transportation provided directly by clients or family members of clients with their own transportation, volunteers using their own vehicles,

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taxicabs, and public transit, or provided to a client who needs a stretcher-accessible vehicle, a lift/ramp equipped vehicle, or a vehicle that is not stretcher-accessible or lift/ramp equipped designed to transport ten or fewer persons. Upon implementation of a new rate structure, a new covered mode of nonemergency medical transportation shall include transportation provided to a client who needs a protected vehicle that is not an ambulance or police car and has safety locks, a video recorder, and a transparent thermoplastic partition between the passenger and the vehicle driver.

(h) The administrative agency shall use the level of service process established by the commissioner in consultation with the Nonemergency Medical Transportation Advisory Committee to determine the client's most appropriate mode of transportation. If public transit or a certified transportation provider is not available to provide the appropriate service mode for the client, the client may receive a onetime service upgrade. The new modes of transportation, which may not be implemented without a new rate structure, are:

(1) client reimbursement, which includes client mileage reimbursement provided to clients who have their own transportation or family who provides transportation to the client;

(2) volunteer transport, which includes transportation by volunteers using their own vehicle;

(3) unassisted transport, which includes transportation provided to a client by a taxicab or public transit. If a taxicab or publicly operated transit system is not available, the client can receive transportation from another nonemergency medical transportation provider;

(4) assisted transport, which includes transport provided to clients who require assistance by a nonemergency medical transportation provider;

(5) lift-equipped/ramp transport, which includes transport provided to a client who is dependent on a device and requires a nonemergency medical transportation provider with a vehicle containing a lift or ramp;

(6) protected transport, which includes transport to a client who has received a prescreening that has deemed other forms of transportation inappropriate and who requires a provider certified as a protected transport provider; and

(7) stretcher transport, which includes transport for a client in a prone or supine position and requires a nonemergency medical transportation provider with a vehicle that can transport a client in a prone or supine position.

(i) In accordance with subdivision 18e, by July 1, 2016, the local agency shall be the single administrative agency and shall administer and reimburse for modes defined in paragraph (h) according to a new rate structure, once this is adopted.

(j) The commissioner shall:

(1) in consultation with the Nonemergency Medical Transportation Advisory Committee, verify that the mode and use of nonemergency medical transportation is appropriate;

(2) verify that the client is going to an approved medical appointment; and

(3) investigate all complaints and appeals.

(k) The administrative agency shall pay for the services provided in this subdivision and seek reimbursement from the commissioner, if appropriate. As vendors of medical care, local agencies are subject to

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the provisions in section 256B.041, the sanctions and monetary recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160 to 9505.2245.

(l) The base rates for special transportation services in areas defined under RUCA to be super rural shall be equal to the reimbursement rate established in paragraph (f), clause (1), plus 11.3 percent, and for special transportation services in areas defined under RUCA to be rural or super rural areas:

(1) for a trip equal to 17 miles or less, mileage reimbursement shall be equal to 125 percent of the respective mileage rate in paragraph (f), clause (1); and

(2) for a trip between 18 and 50 miles, mileage reimbursement shall be equal to 112.5 percent of the respective mileage rate in paragraph (f), clause (1).

(m) For purposes of reimbursement rates for special transportation services under paragraph (c), the zip code of the recipient's place of residence shall determine whether the urban, rural, or super rural reimbursement rate applies.

(n) For purposes of this subdivision, "rural urban commuting area" or "RUCA" means a census-tract based classification system under which a geographical area is determined to be urban, rural, or super rural.

(o) Effective for services provided on or after September 1, 2011, nonemergency transportation rates, including special transportation, taxi, and other commercial carriers, are reduced 4.5 percent. Payments made to managed care plans and county-based purchasing plans must be reduced for services provided on or after January 1, 2012, to reflect this reduction.

Subd. 17a. **Payment for ambulance services.** (a) Medical assistance covers ambulance services. Providers shall bill ambulance services according to Medicare criteria. Nonemergency ambulance services shall not be paid as emergencies. Effective for services rendered on or after July 1, 2001, medical assistance payments for ambulance services shall be paid at the Medicare reimbursement rate or at the medical assistance payment rate in effect on July 1, 2000, whichever is greater.

(b) Effective for services provided on or after September 1, 2011, ambulance services payment rates are reduced 4.5 percent. Payments made to managed care plans and county-based purchasing plans must be reduced for services provided on or after January 1, 2012, to reflect this reduction.

Subd. 18. **Bus or taxicab transportation.** To the extent authorized by rule of the state agency, medical assistance covers the most appropriate and cost-effective form of transportation incurred by any ambulatory eligible person for obtaining nonemergency medical care.

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

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

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

(d) Regardless of the number of employees that an enrolled health care provider may have, medical assistance covers sign and oral language interpreter services when provided by an enrolled health care provider during the course of providing a direct, person-to-person covered health care service to an enrolled recipient

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with limited English proficiency or who has a hearing loss and uses interpreting services. Coverage for face-to-face oral language interpreter services shall be provided only if the oral language interpreter used by the enrolled health care provider is listed in the registry or roster established under section 144.058.

Subd. 18b. **Broker dispatching prohibition.** Except for establishing level of service process, the commissioner shall not use a broker or coordinator for any purpose related to nonemergency medical transportation services under subdivision 18.

Subd. 18c. **Nonemergency Medical Transportation Advisory Committee.** (a) The Nonemergency Medical Transportation Advisory Committee shall advise the commissioner on the administration of nonemergency medical transportation covered under medical assistance. The advisory committee shall meet at least quarterly the first year following January 1, 2015, and at least biannually thereafter and may meet more frequently as required by the commissioner. The advisory committee shall annually elect a chair from among its members, who shall work with the commissioner or the commissioner's designee to establish the agenda for each meeting. The commissioner, or the commissioner's designee, shall attend all advisory committee meetings.

(b) The Nonemergency Medical Transportation Advisory Committee shall advise and make recommendations to the commissioner on:

(1) updates to the nonemergency medical transportation policy manual;

(2) other aspects of the nonemergency medical transportation system, as requested by the commissioner; and

(3) other aspects of the nonemergency medical transportation system, as requested by:

(i) a committee member, who may request an item to be placed on the agenda for a future meeting. The request may be considered by the committee and voted upon. If the motion carries, the meeting agenda item may be developed for presentation to the committee; and

(ii) a member of the public, who may approach the committee by letter or e-mail requesting that an item be placed on a future meeting agenda. The request may be considered by the committee and voted upon. If the motion carries, the agenda item may be developed for presentation to the committee.

(c) The Nonemergency Medical Transportation Advisory Committee shall coordinate its activities with the Minnesota Council on Transportation Access established under section 174.285. The chair of the advisory committee, or the chair's designee, shall attend all meetings of the Minnesota Council on Transportation Access.

(d) The Nonemergency Medical Transportation Advisory Committee shall expire December 1, 2019.

Subd. 18d. **Advisory committee members.** (a) The Nonemergency Medical Transportation Advisory Committee consists of:

(1) four voting members who represent counties, utilizing the rural urban commuting area classification system. As defined in subdivision 17, these members shall be designated as follows:

(i) two counties within the 11-county metropolitan area;

(ii) one county representing the rural area of the state; and

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(iii) one county representing the super rural area of the state.

The Association of Minnesota Counties shall appoint one county within the 11-county metropolitan area and one county representing the super rural area of the state. The Minnesota Inter-County Association shall appoint one county within the 11-county metropolitan area and one county representing the rural area of the state;

(2) three voting members who represent medical assistance recipients, including persons with physical and developmental disabilities, persons with mental illness, seniors, children, and low-income individuals;

(3) four voting members who represent providers that deliver nonemergency medical transportation services to medical assistance enrollees;

(4) two voting members of the house of representatives, one from the majority party and one from the minority party, appointed by the speaker of the house, and two voting members from the senate, one from the majority party and one from the minority party, appointed by the Subcommittee on Committees of the Committee on Rules and Administration;

(5) one voting member who represents demonstration providers as defined in section 256B.69, subdivision 2;

(6) one voting member who represents an organization that contracts with state or local governments to coordinate transportation services for medical assistance enrollees;

(7) one voting member who represents the Minnesota State Council on Disability;

(8) the commissioner of transportation or the commissioner's designee, who shall serve as a voting member;

(9) one voting member appointed by the Minnesota Ambulance Association; and

(10) one voting member appointed by the Minnesota Hospital Association.

(b) Members of the advisory committee shall not be employed by the Department of Human Services. Members of the advisory committee shall receive no compensation.

Subd. 18e. **Single administrative structure and delivery system.** The commissioner shall implement a single administrative structure and delivery system for nonemergency medical transportation, beginning the latter of the date the single administrative assessment tool required in this subdivision is available for use, as determined by the commissioner or by July 1, 2016.

In coordination with the Department of Transportation, the commissioner shall develop and authorize a Web-based single administrative structure and assessment tool, which must operate 24 hours a day, seven days a week, to facilitate the enrollee assessment process for nonemergency medical transportation services. The Web-based tool shall facilitate the transportation eligibility determination process initiated by clients and client advocates; shall include an accessible automated intake and assessment process and real-time identification of level of service eligibility; and shall authorize an appropriate and auditable mode of transportation authorization. The tool shall provide a single framework for reconciling trip information with claiming and collecting complaints regarding inappropriate level of need determinations, inappropriate transportation modes utilized, and interference with accessing nonemergency medical transportation. The Web-based single administrative structure shall operate on a trial basis for one year from implementation

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and, if approved by the commissioner, shall be permanent thereafter. The commissioner shall seek input from the Nonemergency Medical Transportation Advisory Committee to ensure the software is effective and user-friendly and make recommendations regarding funding of the single administrative system.

Subd. 18f. [Repealed, 2014 c 312 art 24 s 48]

Subd. 18g. **Use of standardized measures.** Beginning in calendar year 2015, the commissioner shall collect, audit, and analyze performance data on nonemergency medical transportation annually and report this information on the agency's Web site. The commissioner shall periodically supplement this information with the results of consumer surveys of the quality of services, and shall make these survey findings available to the public on the agency Web site.

Subd. 18h. **Managed care.** The following subdivisions do not apply to managed care plans and county-based purchasing plans:

(1) subdivision 17, paragraphs (d) to (k);

(2) subdivision 18e; and

(3) subdivision 18g.

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

Subd. 19a. **Personal care assistance services.** Medical assistance covers personal care assistance services in a recipient's home. Effective January 1, 2010, to qualify for personal care assistance services, a recipient must require assistance and be determined dependent in one activity of daily living as defined in section 256B.0659, subdivision 1, paragraph (b), or in a Level I behavior as defined in section 256B.0659, subdivision 1, paragraph (c). Recipients or responsible parties must be able to identify the recipient's needs, direct and evaluate task accomplishment, and provide for health and safety. Approved hours may be used outside the home when normal life activities take them outside the home. To use personal care assistance services at school, the recipient or responsible party must provide written authorization in the care plan identifying the chosen provider and the daily amount of services to be used at school. Total hours for services, whether actually performed inside or outside the recipient's home, cannot exceed that which is otherwise allowed for personal care assistance services in an in-home setting according to sections 256B.0651 to 256B.0654. Medical assistance does not cover personal care assistance services for residents of a hospital, nursing facility, intermediate care facility, health care facility licensed by the commissioner of health, or unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the personal care assistance services or forgoes the facility per diem for the leave days that personal care assistance services are used. All personal care assistance services must be provided according to sections 256B.0651 to 256B.0654. Personal care assistance services may not be reimbursed if the personal care assistant is the spouse or paid guardian of the recipient or the parent of a recipient under age 18, or the responsible party or the family foster care provider of a recipient who cannot direct the recipient's own care unless, in the case of a foster care provider, a county or state case manager visits the recipient as needed, but not less than every six months, to monitor the health and safety of the recipient and to ensure the goals of the care plan are met. Notwithstanding the provisions of section 256B.0659, the unpaid guardian or conservator of an adult, who is not the responsible party and not the personal care provider organization, may be reimbursed to provide personal care assistance services to the recipient if the guardian or conservator meets all criteria for a personal care assistant according to section 256B.0659, and shall not be considered to have a service provider interest for purposes of participation on the screening team under section 256B.092, subdivision 7.

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Subd. 19b. **No automatic adjustment.** For fiscal years beginning on or after July 1, 1993, the commissioner of human services shall not provide automatic annual inflation adjustments for home care services. The commissioner of management and budget shall include as a budget change request in each biennial detailed expenditure budget submitted to the legislature under section 16A.11 annual adjustments in reimbursement rates for home care services.

Subd. 19c. **Personal care.** Medical assistance covers personal care assistance services provided by an individual who is qualified to provide the services according to subdivision 19a and sections 256B.0651 to 256B.0654, provided in accordance with a plan, and supervised by a qualified professional.

"Qualified professional" means a mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6); a registered nurse as defined in sections 148.171 to 148.285, a licensed social worker as defined in sections 148E.010 and 148E.055, or a qualified designated coordinator under section 245D.081, subdivision 2. The qualified professional shall perform the duties required in section 256B.0659.

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 245.4887, the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

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

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

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

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

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

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

(f) Payment for mental health case management provided by vendors who contract with a county or Indian tribe shall be based on a monthly rate negotiated by the host county or tribe. The negotiated rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the county or tribe may negotiate a team rate with a vendor who is a member

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of the team. The team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county or tribe, except to reimburse the county or tribe for advance funding provided by the county or tribe to the vendor.

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

(h) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for mental health case management shall be provided by the recipient's county of responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds used to match other federal funds. If the service is provided by a tribal agency, the nonfederal share, if any, shall be provided by the recipient's tribe. When this service is paid by the state without a federal share through fee-for-service, 50 percent of the cost shall be provided by the recipient's county of responsibility.

(i) Notwithstanding any administrative rule to the contrary, prepaid medical assistance, general assistance medical care, and MinnesotaCare include mental health case management. When the service is provided through prepaid capitation, the nonfederal share is paid by the state and the county pays no share.

(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, or, if applicable, the tribal agency, is responsible for any federal disallowances. The county or tribe may share this responsibility with its contracted vendors.

(k) The commissioner shall set aside a portion of the federal funds earned for county expenditures 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) Payments to counties and tribal agencies for case management expenditures under this section shall only be made from federal earnings from services provided under this section. When this service is paid by the state without a federal share through fee-for-service, 50 percent of the cost shall be provided by the state. Payments to county-contracted vendors shall include the federal earnings, the state share, and the county share.

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

(n) 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 lesser of:

(1) the last 180 days of the recipient's residency in that facility and may not exceed more than six months in a calendar year; or

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(2) the limits and conditions which apply to federal Medicaid funding for this service.

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

Subd. 20a. **Case management; developmental disabilities.** To the extent defined in the state Medicaid plan, case management service activities for persons with developmental disabilities as defined in section 256B.092, and rules promulgated thereunder, are covered services under medical assistance.

Subd. 21. [Repealed, 1989 c 282 art 3 s 98]

Subd. 22. **Hospice care.** Medical assistance covers hospice care services under Public Law 99-272, section 9505, to the extent authorized by rule, except that a recipient age 21 or under who elects to receive hospice services does not waive coverage for services that are related to the treatment of the condition for which a diagnosis of terminal illness has been made.

Subd. 23. **Day treatment services.** Medical assistance covers day treatment services as specified in sections 245.462, subdivision 8, and 245.4871, subdivision 10, that are provided under contract with the county board. The commissioner may set authorization thresholds for day treatment for adults according to subdivision 25. Medical assistance covers day treatment services for children as specified under section 256B.0943.

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

Subd. 25. **Prior authorization required.** (a) The commissioner shall publish in the Minnesota health care programs provider manual and on the department's Web site a list of health services that require prior authorization, the criteria and standards used to select health services on the list, and the criteria and standards used to determine whether certain providers must obtain prior authorization for their services. The list of services requiring prior authorization and the criteria and standards used to formulate the list of services or the selection of providers for whom prior authorization is required are not subject to the requirements of sections 14.001 to 14.69. The commissioner's decision whether prior authorization is required for a health service or is required for a provider is not subject to administrative appeal. Use of criteria or standards to select providers for whom prior authorization is required shall not impede access to the service involved for any group of individuals with unique or special needs due to disability or functional condition.

(b) The commissioner shall implement a modernized electronic system for providers to request prior authorization. The modernized electronic system must include at least the following functionalities:

(1) authorizations are recipient-centric, not provider-centric;

(2) adequate flexibility to support authorizations for an episode of care, continuous drug therapy, or for individual onetime services and allows an ordering and a rendering provider to both submit information into one request;

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(3) allows providers to review previous authorization requests and determine where a submitted request is within the authorization process;

(4) supports automated workflows that allow providers to securely submit medical information that can be accessed by medical and pharmacy review vendors as well as department staff; and

(5) supports development of automated clinical algorithms that can verify information and provide responses in real time.

(c) The system described in paragraph (b) shall be completed by March 1, 2012. All authorization requests submitted on and after March 1, 2012, or upon completion of the modernized authorization system, whichever is later, must be submitted electronically by providers, except requests for drugs dispensed by an outpatient pharmacy, services that are provided outside of the state and surrounding local trade area, and services included on a service agreement.

Subd. 25a. **Prior authorization of diagnostic imaging services.** (a) Effective January 1, 2010, the commissioner shall require prior authorization or decision support for the ordering providers at the time the service is ordered for the following outpatient diagnostic imaging services: computerized tomography (CT), magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positive emission tomography (PET), cardiac imaging, and ultrasound diagnostic imaging.

(b) Prior authorization under this subdivision is not required for diagnostic imaging services performed as part of a hospital emergency room visit, inpatient hospitalization, or if concurrent with or on the same day as an urgent care facility visit.

(c) This subdivision does not apply to services provided to recipients who are enrolled in Medicare, the prepaid medical assistance program, the prepaid general assistance medical care program, or the MinnesotaCare program.

(d) The commissioner may contract with a private entity to provide the prior authorization or decision support required under this subdivision. The contracting entity must incorporate clinical guidelines that are based on evidence-based medical literature, if available. By January 1, 2012, the contracting entity shall report to the commissioner the results of prior authorization or decision support.

Subd. 25b. **Authorization with third-party liability.** (a) Except as otherwise allowed under this subdivision or required under federal or state regulations, the commissioner must not consider a request for authorization of a service when the recipient has coverage from a third-party payer unless the provider requesting authorization has made a good faith effort to receive payment or authorization from the third-party payer. A good faith effort is established by supplying with the authorization request to the commissioner the following:

(1) a determination of payment for the service from the third-party payer, a determination of authorization for the service from the third-party payer, or a verification of noncoverage of the service by the third-party payer; and

(2) the information or records required by the department to document the reason for the determination or to validate noncoverage from the third-party payer.

(b) A provider requesting authorization for services covered by Medicare is not required to bill Medicare before requesting authorization from the commissioner if the provider has reason to believe that a service covered by Medicare is not eligible for payment. The provider must document that, because of recent claim

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experiences with Medicare or because of written communication from Medicare, coverage is not available for the service.

(c) Authorization is not required if a third-party payer has made payment that is equal to or greater than 60 percent of the maximum payment amount for the service allowed under medical assistance.

Subd. 26. **Special education services.** (a) Medical assistance covers medical services identified in a recipient's individualized education program 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, health assessments, 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 individualized education program 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 individualized education program 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 individualized education program 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 individualized education program 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.

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(f) The commissioner shall develop a cost-based payment structure for payment of these services. Only costs reported through the designated Minnesota Department of Education data systems in distinct service categories qualify for inclusion in the cost-based payment structure. The commissioner shall reimburse claims submitted based on an interim rate, and shall settle at a final rate once the department has determined it. The commissioner shall notify the school district of the final rate. The school district has 60 days to appeal the final rate. To appeal the final rate, the school district shall file a written appeal request to the commissioner within 60 days of the date the final rate determination was mailed. The appeal request shall specify (1) the disputed items and (2) the name and address of the person to contact regarding the appeal.

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

(h) Nursing services as defined in section 148.171, subdivision 15, and provided as an individualized education program health-related service, are eligible for medical assistance payment if they are otherwise a covered service under the medical assistance program. Medical assistance covers the administration of prescription medications by a licensed nurse who is employed by or under contract with a school district when the administration of medications is identified in the child's individualized education program. The simple administration of medications alone is not covered under medical assistance when administered by a provider other than a school district or when it is not identified in the child's individualized education program.

Subd. 27. **Organ and tissue transplants.** All organ transplants must be performed at transplant centers meeting united network for organ sharing criteria or at Medicare-approved organ transplant centers. Stem cell or bone marrow transplant centers must meet the standards established by the Foundation for the Accreditation of Hematopoietic Cell Therapy.

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.

Subd. 28a. **Licensed physician assistant services.** (a) Medical assistance covers services performed by a licensed physician assistant if the service is otherwise covered under this chapter as a physician service and if the service is within the scope of practice of a licensed physician assistant as defined in section 147A.09.

(b) Licensed physician assistants, who are supervised by a physician certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry, may bill for medication management and evaluation and management services provided to medical assistance enrollees in inpatient hospital settings, consistent with their authorized scope of practice, as defined in section 147A.09, with the exception of performing psychotherapy or diagnostic assessments or providing clinical supervision.

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Subd. 28b. **Doula services.** Medical assistance covers doula services provided by a certified doula as defined in section 148.995, subdivision 2, of the mother's choice. For purposes of this section, "doula services" means childbirth education and support services, including emotional and physical support provided during pregnancy, labor, birth, and postpartum.

[See Note.]

Subd. 29. **Public health nursing clinic services.** Medical assistance covers the services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic that is a department of, or that operates under the direct authority of, a unit of government, if the service is within the scope of practice of the public health or registered nurse's license as a registered nurse, as defined in section 148.171.

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

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

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

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

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

(f) Effective January 1, 2001, each federally qualified health center and rural health clinic may elect to be paid either under the prospective payment system established in United States Code, title 42, section

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1396a(aa), or under an alternative payment methodology consistent with the requirements of United States Code, title 42, section 1396a(aa), and approved by the Centers for Medicare and Medicaid Services. The alternative payment methodology shall be 100 percent of cost as determined according to Medicare cost principles.

(g) For purposes of this section, "nonprofit community clinic" is a clinic that:

(1) has nonprofit status as specified in chapter 317A;

(2) has tax exempt status as provided in Internal Revenue Code, section 501(c)(3);

(3) is established to provide health services to low-income population groups, uninsured, high-risk and special needs populations, underserved and other special needs populations;

(4) employs professional staff at least one-half of which are familiar with the cultural background of their clients;

(5) charges for services on a sliding fee scale designed to provide assistance to low-income clients based on current poverty income guidelines and family size; and

(6) does not restrict access or services because of a client's financial limitations or public assistance status and provides no-cost care as needed.

(h) Effective for services provided on or after January 1, 2015, all claims for payment of clinic services provided by federally qualified health centers and rural health clinics shall be paid by the commissioner. The commissioner shall determine the most feasible method for paying claims from the following options:

(1) federally qualified health centers and rural health clinics submit claims directly to the commissioner for payment, and the commissioner provides claims information for recipients enrolled in a managed care or county-based purchasing plan to the plan, on a regular basis; or

(2) federally qualified health centers and rural health clinics submit claims for recipients enrolled in a managed care or county-based purchasing plan to the plan, and those claims are submitted by the plan to the commissioner for payment to the clinic.

(i) For clinic services provided prior to January 1, 2015, the commissioner shall calculate and pay monthly the proposed managed care supplemental payments to clinics, and clinics shall conduct a timely review of the payment calculation data in order to finalize all supplemental payments in accordance with federal law. Any issues arising from a clinic's review must be reported to the commissioner by January 1, 2017. Upon final agreement between the commissioner and a clinic on issues identified under this subdivision, and in accordance with United States Code, title 42, section 1396a(bb), no supplemental payments for managed care plan or county-based purchasing plan claims for services provided prior to January 1, 2015, shall be made after June 30, 2017. If the commissioner and clinics are unable to resolve issues under this subdivision, the parties shall submit the dispute to the arbitration process under section 14.57.

Subd. 31. **Medical supplies and equipment.** (a) Medical assistance covers medical supplies and equipment. Separate payment outside of the facility's payment rate shall be made for wheelchairs and wheelchair accessories for recipients who are residents of intermediate care facilities for the developmentally disabled. Reimbursement for wheelchairs and wheelchair accessories for ICF/DD recipients shall be subject to the same conditions and limitations as coverage for recipients who do not reside in institutions. A wheelchair purchased outside of the facility's payment rate is the property of the recipient. The commissioner

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may set reimbursement rates for specified categories of medical supplies at levels below the Medicare payment rate.

(b) Vendors of durable medical equipment, prosthetics, orthotics, or medical supplies must enroll as a Medicare provider.

(c) When necessary to ensure access to durable medical equipment, prosthetics, orthotics, or medical supplies, the commissioner may exempt a vendor from the Medicare enrollment requirement if:

(1) the vendor supplies only one type of durable medical equipment, prosthetic, orthotic, or medical supply;

(2) the vendor serves ten or fewer medical assistance recipients per year;

(3) the commissioner finds that other vendors are not available to provide same or similar durable medical equipment, prosthetics, orthotics, or medical supplies; and

(4) the vendor complies with all screening requirements in this chapter and Code of Federal Regulations, title 42, part 455. The commissioner may also exempt a vendor from the Medicare enrollment requirement if the vendor is accredited by a Centers for Medicare and Medicaid Services approved national accreditation organization as complying with the Medicare program's supplier and quality standards and the vendor serves primarily pediatric patients.

(d) Durable medical equipment means a device or equipment that:

(1) can withstand repeated use;

(2) is generally not useful in the absence of an illness, injury, or disability; and

(3) is provided to correct or accommodate a physiological disorder or physical condition or is generally used primarily for a medical purpose.

(e) Electronic tablets may be considered durable medical equipment if the electronic tablet will be used as an augmentative and alternative communication system as defined under subdivision 31a, paragraph (a). To be covered by medical assistance, the device must be locked in order to prevent use not related to communication.

Subd. 31a. **Augmentative and alternative communication systems.** (a) Medical assistance covers augmentative and alternative communication systems consisting of electronic or nonelectronic devices and the related components necessary to enable a person with severe expressive communication limitations to produce or transmit messages or symbols in a manner that compensates for that disability.

(b) Augmentative and alternative communication systems must be paid the lower of the:

(1) submitted charge; or

(2)(i) manufacturer's suggested retail price minus 20 percent for providers that are manufacturers of augmentative and alternative communication systems; or

(ii) manufacturer's invoice charge plus 20 percent for providers that are not manufacturers of augmentative and alternative communication systems.

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(c) Reimbursement rates established by this purchasing program are not subject to Minnesota Rules, part 9505.0445, item S or T.

Subd. 31b. **Preferred diabetic testing supply program.** (a) The commissioner shall implement a point-of-sale preferred diabetic testing supply program by January 1, 2014. Medical assistance coverage for diabetic testing supplies shall conform to the limitations established under the program. The commissioner may enter into a contract with a vendor for the purpose of participating in a preferred diabetic testing supply list and supplemental rebate program. The commissioner shall ensure that any contract meets all federal requirements and maximizes federal financial participation. The commissioner shall maintain an accurate and up-to-date list on the department's Web site.

(b) The commissioner may add to, delete from, and otherwise modify the preferred diabetic testing supply program drug list after consulting with the Drug Formulary Committee and appropriate medical specialists and providing public notice and the opportunity for public comment.

(c) The commissioner shall adopt and administer the preferred diabetic testing supply program as part of the administration of the diabetic testing supply rebate program. Reimbursement for diabetic testing supplies not on the preferred diabetic testing supply list may be subject to prior authorization.

(d) All claims for diabetic testing supplies in categories on the preferred diabetic testing supply list must be submitted by enrolled pharmacy providers using the most current National Council of Prescription Drug Plans electronic claims standard.

(e) For purposes of this subdivision, "preferred diabetic testing supply list" means a list of diabetic testing supplies selected by the commissioner, for which prior authorization is not required.

(f) The commissioner shall seek any federal waivers or approvals necessary to implement this subdivision.

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.10 to be:

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

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

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

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

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

Subd. 35. [Repealed, 1Sp2003 c 14 art 4 s 24]

Subd. 35a. **Children's mental health crisis response services.** Medical assistance covers children's mental health crisis response services according to section 256B.0944.

Subd. 35b. **Children's therapeutic services and supports.** Medical assistance covers children's therapeutic services and supports according to section 256B.0943.

Subd. 36. [Repealed, 1Sp2003 c 14 art 4 s 24]

Subd. 37. **Individualized rehabilitation services.** Medical assistance covers individualized rehabilitation services as defined in section 245.492, subdivision 23, that are provided by a collaborative, county, or an entity under contract with a county through an integrated service system, as described in section 245.4931, that is approved by the state coordinating council, subject to federal approval.

Subd. 38. **Payments for mental health services.** Payments for mental health services covered under the medical assistance program that are provided by masters-prepared mental health professionals shall be 80 percent of the rate paid to doctoral-prepared professionals. Payments for mental health services covered under the medical assistance program that are provided by masters-prepared mental health professionals employed by community mental health centers shall be 100 percent of the rate paid to doctoral-prepared professionals. Payments for mental health services covered under the medical assistance program that are provided by physician assistants shall be 80.4 percent of the base rate paid to psychiatrists.

Subd. 39. **Childhood immunizations.** Providers who administer pediatric vaccines within the scope of their licensure, and who are enrolled as a medical assistance provider, must enroll in the pediatric vaccine administration program established by section 13631 of the Omnibus Budget Reconciliation Act of 1993. Medical assistance shall pay for administration of the vaccine to children eligible for medical assistance. Medical assistance does not pay for vaccines that are available at no cost from the pediatric vaccine administration program.

Subd. 40. **Tuberculosis related services.** (a) For persons infected with tuberculosis, medical assistance covers case management services and direct observation of the intake of drugs prescribed to treat tuberculosis.

(b) "Case management services" means services furnished to assist persons infected with tuberculosis in gaining access to needed medical services. Case management services include at a minimum:

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(1) assessing a person's need for medical services to treat tuberculosis;

(2) developing a care plan that addresses the needs identified in clause (1);

(3) assisting the person in accessing medical services identified in the care plan; and

(4) monitoring the person's compliance with the care plan to ensure completion of tuberculosis therapy. Medical assistance covers case management services under this subdivision only if the services are provided by a certified public health nurse who is employed by a community health board as defined in section 145A.02, subdivision 5.

(c) To be covered by medical assistance, direct observation of the intake of drugs prescribed to treat tuberculosis must be provided by a community outreach worker, licensed practical nurse, registered nurse who is trained and supervised by a public health nurse employed by a community health board as defined in section 145A.02, subdivision 5, or a public health nurse employed by a community health board.

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 or an American Indian tribe 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.

Subd. 42. **Mental health professional.** Notwithstanding Minnesota Rules, part 9505.0175, subpart 28, the definition of a mental health professional shall include a person who is qualified as specified in section 245.462, subdivision 18, clauses (1) to (6); or 245.4871, subdivision 27, clauses (1) to (6), for the purpose of this section and Minnesota Rules, parts 9505.0170 to 9505.0475.

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

Subd. 44. **Targeted case management services.** Medical assistance covers case management services for vulnerable adults and adults with developmental disabilities, as provided under section 256B.0924.

Subd. 45. **Subacute psychiatric care for persons under 21 years of age.** Medical assistance covers subacute psychiatric care for person under 21 years of age when:

(1) the services meet the requirements of Code of Federal Regulations, title 42, section 440.160;

(2) the facility is accredited as a psychiatric treatment facility by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation; and

(3) the facility is licensed by the commissioner of health under section 144.50.

Subd. 46. **Mental health telemedicine.** Effective January 1, 2006, and subject to federal approval, mental health services that are otherwise covered by medical assistance as direct face-to-face services may be provided via two-way interactive video. Use of two-way interactive video must be medically appropriate to the condition and needs of the person being served. Reimbursement is at the same rates and under the

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same conditions that would otherwise apply to the service. The interactive video equipment and connection must comply with Medicare standards in effect at the time the service is provided.

Subd. 47. **Treatment foster care services.** Effective July 1, 2011, and subject to federal approval, medical assistance covers treatment foster care services according to section 256B.0946.

Subd. 48. **Psychiatric consultation to primary care practitioners.** Medical assistance covers consultation provided by a psychiatrist, a psychologist, or an advanced practice registered nurse certified in psychiatric mental health via telephone, e-mail, facsimile, or other means of communication to primary care practitioners, including pediatricians. The need for consultation and the receipt of the consultation must be documented in the patient record maintained by the primary care practitioner. If the patient consents, and subject to federal limitations and data privacy provisions, the consultation may be provided without the patient present.

Subd. 49. **Community health worker.** (a) Medical assistance covers the care coordination and patient education services provided by a community health worker if the community health worker has:

(1) received a certificate from the Minnesota State Colleges and Universities System approved community health worker curriculum; or

(2) at least five years of supervised experience with an enrolled physician, registered nurse, advanced practice registered nurse, mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6), and section 245.4871, subdivision 27, clauses (1) to (5), or dentist, or at least five years of supervised experience by a certified public health nurse operating under the direct authority of an enrolled unit of government.

Community health workers eligible for payment under clause (2) must complete the certification program by January 1, 2010, to continue to be eligible for payment.

(b) Community health workers must work under the supervision of a medical assistance enrolled physician, registered nurse, advanced practice registered nurse, mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6), and section 245.4871, subdivision 27, clauses (1) to (5), or dentist, or work under the supervision of a certified public health nurse operating under the direct authority of an enrolled unit of government.

(c) Care coordination and patient education services covered under this subdivision include, but are not limited to, services relating to oral health and dental care.

Subd. 50. **Self-directed supports option.** Upon federal approval, medical assistance covers the self-directed supports option as defined under section 256B.0657 and section 6087 of the Federal Deficit Reduction Act of 2005, Public Law 109-171.

[See Note.]

Subd. 51. **Provider-directed care coordination services.** The commissioner shall develop and implement a provider-directed care coordination program for medical assistance recipients who are not enrolled in the prepaid medical assistance program and who are receiving services on a fee-for-service basis. This program provides payment to primary care clinics for care coordination for people who have complex and chronic medical conditions. Clinics must meet certain criteria such as the capacity to develop care plans; have a dedicated care coordinator; and have an adequate number of fee-for-service clients, evaluation mechanisms, and quality improvement processes to qualify for reimbursement. For purposes of this sub-

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division, a primary care clinic is a medical clinic designated as the patient's first point of contact for medical care, available 24 hours a day, seven days a week, that provides or arranges for the patient's comprehensive health care needs, and provides overall integration, coordination and continuity over time and referrals for specialty care.

Subd. 52. **Lead risk assessments.** (a) Effective October 1, 2007, or six months after federal approval, whichever is later, medical assistance covers lead risk assessments provided by a lead risk assessor who is licensed by the commissioner of health under section 144.9505 and employed by an assessing agency as defined in section 144.9501. Medical assistance covers a onetime on-site investigation of a recipient's home or primary residence to determine the existence of lead so long as the recipient is under the age of 21 and has a venous blood lead level specified in section 144.9504, subdivision 2, paragraph (a).

(b) Medical assistance reimbursement covers the lead risk assessor's time to complete the following activities:

(1) gathering samples;

(2) interviewing family members;

(3) gathering data, including meter readings; and

(4) providing a report with the results of the investigation and options for reducing lead-based paint hazards.

Medical assistance coverage of lead risk assessment does not include testing of environmental substances such as water, paint, or soil or any other laboratory services. Medical assistance coverage of lead risk assessments is not included in the capitated services for children enrolled in health plans through the prepaid medical assistance program and the MinnesotaCare program.

(c) Payment for lead risk assessment must be cost-based and must meet the criteria for federal financial participation under the Medicaid program. The rate must be based on allowable expenditures from cost information gathered. Under section 144.9507, subdivision 5, federal medical assistance funds may not replace existing funding for lead-related activities. The nonfederal share of costs for services provided under this subdivision must be from state or local funds and is the responsibility of the agency providing the risk assessment. When the risk assessment is conducted by the commissioner of health, the state share must be from appropriations to the commissioner of health for this purpose. Eligible expenditures for the nonfederal share of costs may not be made from federal funds or funds used to match other federal funds. Any federal disallowances are the responsibility of the agency providing risk assessment services.

Subd. 53. **Centers of excellence.** For complex medical procedures with a high degree of variation in outcomes, for which the Medicare program requires facilities providing the services to meet certain criteria as a condition of coverage, the commissioner may develop centers of excellence facility criteria in consultation with the Health Services Policy Committee under subdivision 3c. The criteria must reflect facility traits that have been linked to superior patient safety and outcomes for the procedures in question, and must be based on the best available empirical evidence. For medical assistance recipients enrolled on a fee-for-service basis, the commissioner may make coverage for these procedures conditional upon the facility providing the services meeting the specified criteria. Only facilities meeting the criteria may be reimbursed for the procedures in question.

[See Note.]

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Subd. 54. **Services provided in birth centers.** (a) Medical assistance covers services provided in a licensed birth center by a licensed health professional if the service would otherwise be covered if provided in a hospital.

(b) Facility services provided by a birth center shall be paid at the lower of billed charges or 70 percent of the statewide average for a facility payment rate made to a hospital for an uncomplicated vaginal birth as determined using the most recent calendar year for which complete claims data is available. If a recipient is transported from a birth center to a hospital prior to the delivery, the payment for facility services to the birth center shall be the lower of billed charges or 15 percent of the average facility payment made to a hospital for the services provided for an uncomplicated vaginal delivery as determined using the most recent calendar year for which complete claims data is available.

(c) Nursery care services provided by a birth center shall be paid the lower of billed charges or 70 percent of the statewide average for a payment rate paid to a hospital for nursery care as determined by using the most recent calendar year for which complete claims data is available.

(d) Professional services provided by traditional midwives licensed under chapter 147D shall be paid at the lower of billed charges or 100 percent of the rate paid to a physician performing the same services. If a recipient is transported from a birth center to a hospital prior to the delivery, a licensed traditional midwife who does not perform the delivery may not bill for any delivery services. Services are not covered if provided by an unlicensed traditional midwife.

(e) The commissioner shall apply for any necessary waivers from the Centers for Medicare and Medicaid Services to allow birth centers and birth center providers to be reimbursed.

Subd. 55. **Payment for noncovered services.** (a) Except when specifically prohibited by the commissioner or federal law, a provider may seek payment from the recipient for services not eligible for payment under the medical assistance program when the provider, prior to delivering the service, reviews and considers all other available covered alternatives with the recipient and obtains a signed acknowledgment from the recipient of the potential of the recipient's liability. The signed acknowledgment must be in a form approved by the commissioner.

(b) Conditions under which a provider must not request payment from the recipient include, but are not limited to:

(1) a service that requires prior authorization, unless authorization has been denied as not medically necessary and all other therapeutic alternatives have been reviewed;

(2) a service for which payment has been denied for reasons relating to billing requirements;

(3) standard shipping or delivery and setup of medical equipment or medical supplies;

(4) services that are included in the recipient's long term care per diem;

(5) the recipient is enrolled in the Restricted Recipient Program and the provider is one of a provider type designated for the recipient's health care services; and

(6) the noncovered service is a prescription drug identified by the commissioner as having the potential for abuse and overuse, except where payment by the recipient is specifically approved by the commissioner

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on the date of service based upon compelling evidence supplied by the prescribing provider that establishes medical necessity for that particular drug.

(c) The payment requested from recipients for noncovered services under this subdivision must not exceed the provider's usual and customary charge for the actual service received by the recipient. A recipient must not be billed for the difference between what medical assistance paid for the service or would pay for a less costly alternative service.

Subd. 56. **Medical service coordination.** (a)(1) Medical assistance covers in-reach community-based service coordination that is performed through a hospital emergency department as an eligible procedure under a state healthcare program for a frequent user. A frequent user is defined as an individual who has frequented the hospital emergency department for services three or more times in the previous four consecutive months. In-reach community-based service coordination includes navigating services to address a client's mental health, chemical health, social, economic, and housing needs, or any other activity targeted at reducing the incidence of emergency room and other nonmedically necessary health care utilization.

(2) Medical assistance covers in-reach community-based service coordination that is performed through a hospital emergency department or inpatient psychiatric unit for a child or young adult up to age 21 with a serious emotional disturbance who has frequented the hospital emergency room two or more times in the previous consecutive three months or been admitted to an inpatient psychiatric unit two or more times in the previous consecutive four months, or is being discharged to a shelter.

(b) Reimbursement must be made in 15-minute increments and allowed for up to 60 days posthospital discharge based upon the specific identified emergency department visit or inpatient admitting event. In-reach community-based service coordination shall seek to connect frequent users with existing covered services available to them, including, but not limited to, targeted case management, waiver case management, or care coordination in a health care home. For children and young adults with a serious emotional disturbance, in-reach community-based service coordination includes navigating and arranging for community-based services prior to discharge to address a client's mental health, chemical health, social, educational, family support and housing needs, or any other activity targeted at reducing multiple incidents of emergency room use, inpatient readmissions, and other nonmedically necessary health care utilization. In-reach services shall seek to connect them with existing covered services, including targeted case management, waiver case management, care coordination in a health care home, children's therapeutic services and supports, crisis services, and respite care. Eligible in-reach service coordinators must hold a minimum of a bachelor's degree in social work, public health, corrections, or a related field. The commissioner shall submit any necessary application for waivers to the Centers for Medicare and Medicaid Services to implement this subdivision.

(c) (1) For the purposes of this subdivision, "in-reach community-based service coordination" means the practice of a community-based worker with training, knowledge, skills, and ability to access a continuum of services, including housing, transportation, chemical and mental health treatment, employment, education, and peer support services, by working with an organization's staff to transition an individual back into the individual's living environment. In-reach community-based service coordination includes working with the individual during their discharge and for up to a defined amount of time in the individual's living environment, reducing the individual's need for readmittance.

(2) Hospitals utilizing in-reach service coordinators shall report annually to the commissioner on the number of adults, children, and adolescents served; the postdischarge services which they accessed; and emergency department/psychiatric hospitalization readmissions. The commissioner shall ensure that

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services and payments provided under in-reach care coordination do not duplicate services or payments provided under section 256B.0753, 256B.0755, or 256B.0625, subdivision 20.

Subd. 57. **Payment for Part B Medicare crossover claims.** Effective for services provided on or after January 1, 2012, medical assistance payment for an enrollee's cost-sharing associated with Medicare Part B is limited to an amount up to the medical assistance total allowed, when the medical assistance rate exceeds the amount paid by Medicare. Excluded from this limitation are payments for mental health services and payments for dialysis services provided to end-stage renal disease patients. The exclusion for mental health services does not apply to payments for physician services provided by psychiatrists and advanced practice nurses with a specialty in mental health.

Subd. 58. **Early and periodic screening, diagnosis, and treatment services.** Medical assistance covers early and periodic screening, diagnosis, and treatment services (EPSDT). The payment amount for a complete EPSDT screening shall not include charges for vaccines that are available at no cost to the provider and shall not exceed the rate established per Minnesota Rules, part 9505.0445, item M, effective October 1, 2010.

Subd. 59. **Services provided by advanced dental therapists and dental therapists.** Medical assistance covers services provided by advanced dental therapists and dental therapists when provided within the scope of practice identified in sections 150A.105 and 150A.106.

Subd. 60. **Community paramedic services.** (a) Medical assistance covers services provided by community paramedics who are certified under section 144E.28, subdivision 9, when the services are provided in accordance with this subdivision to an eligible recipient as defined in paragraph (b).

(b) For purposes of this subdivision, an eligible recipient is defined as an individual who has received hospital emergency department services three or more times in a period of four consecutive months in the past 12 months or an individual who has been identified by the individual's primary health care provider for whom community paramedic services identified in paragraph (c) would likely prevent admission to or would allow discharge from a nursing facility; or would likely prevent readmission to a hospital or nursing facility.

(c) Payment for services provided by a community paramedic under this subdivision must be a part of a care plan ordered by a primary health care provider in consultation with the medical director of an ambulance service and must be billed by an eligible provider enrolled in medical assistance that employs or contracts with the community paramedic. The care plan must ensure that the services provided by a community paramedic are coordinated with other community health providers and local public health agencies and that community paramedic services do not duplicate services already provided to the patient, including home health and waiver services. Community paramedic services shall include health assessment, chronic disease monitoring and education, medication compliance, immunizations and vaccinations, laboratory specimen collection, hospital discharge follow-up care, and minor medical procedures approved by the ambulance medical director.

(d) Services provided by a community paramedic to an eligible recipient who is also receiving care coordination services must be in consultation with the providers of the recipient's care coordination services.

(e) The commissioner shall seek the necessary federal approval to implement this subdivision.

Subd. 61. **Family psychoeducation services.** Effective July 1, 2013, or upon federal approval, whichever is later, medical assistance covers family psychoeducation services provided to a child up to age 21 with a diagnosed mental health condition when identified in the child's individual treatment plan and

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provided by a licensed mental health professional, as defined in Minnesota Rules, part 9505.0371, subpart 5, item A, or a clinical trainee, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C, who has determined it medically necessary to involve family members in the child's care. For the purposes of this subdivision, "family psychoeducation services" means information or demonstration provided to an individual or family as part of an individual, family, multifamily group, or peer group session to explain, educate, and support the child and family in understanding a child's symptoms of mental illness, the impact on the child's development, and needed components of treatment and skill development so that the individual, family, or group can help the child to prevent relapse, prevent the acquisition of comorbid disorders, and achieve optimal mental health and long-term resilience.

Subd. 62. **Mental health clinical care consultation.** Effective July 1, 2013, or upon federal approval, whichever is later, medical assistance covers clinical care consultation for a person up to age 21 who is diagnosed with a complex mental health condition or a mental health condition that co-occurs with other complex and chronic conditions, when described in the person's individual treatment plan and provided by a licensed mental health professional, as defined in Minnesota Rules, part 9505.0371, subpart 5, item A, or a clinical trainee, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C. For the purposes of this subdivision, "clinical care consultation" means communication from a treating mental health professional to other providers or educators not under the clinical supervision of the treating mental health professional who are working with the same client to inform, inquire, and instruct regarding the client's symptoms; strategies for effective engagement, care, and intervention needs; and treatment expectations across service settings; and to direct and coordinate clinical service components provided to the client and family.

Subd. 63. **Payment for multiple services provided on the same day.** The commissioner shall not prohibit payment, including supplemental payments, for mental health services or dental services provided to a patient by a clinic or health care professional solely because the mental health or dental services were provided on the same day as other covered health services furnished by the same provider.

History: *Ex1967 c 16 s 2; 1969 c 395 s 1; 1973 c 717 s 17; 1975 c 247 s 9; 1975 c 384 s 1; 1975 c 437 art 2 s 3; 1976 c 173 s 56; 1976 c 236 s 1; 1976 c 312 s 1; 1978 c 508 s 2; 1978 c 560 s 10; 1981 c 360 art 2 s 26,54; 1Sp1981 c 2 s 12; 1Sp1981 c 4 art 4 s 22; 3Sp1981 c 2 art 1 s 31; 1982 c 562 s 2; 1983 c 151 s 1,2; 1983 c 312 art 1 s 27; art 5 s 10; art 9 s 4; 1984 c 654 art 5 s 58; 1985 c 21 s 52-54; 1985 c 49 s 41; 1985 c 252 s 19,20; 1Sp1985 c 3 s 19; 1986 c 394 s 17; 1986 c 444; 1987 c 309 s 24; 1987 c 370 art 1 s 3; art 2 s 4; 1987 c 374 s 1; 1987 c 403 art 2 s 73,74; art 5 s 16; 1988 c 689 art 2 s 141,268; 1989 c 282 art 3 s 54-58; 1990 c 422 s 10; 1990 c 568 art 3 s 43-50,104; 1991 c 199 art 2 s 1; 1991 c 292 art 4 s 41-49; art 6 s 45; art 7 s 5,9-11; 1992 c 391 s 1,2; 1992 c 513 art 7 s 43-49; art 9 s 25; 1993 c 246 s 1,2; 1993 c 247 art 4 s 11; 1993 c 345 art 13 s 1; 1Sp1993 c 1 art 3 s 23; art 5 s 36-49; art 7 s 41-44; art 9 s 71; 1Sp1993 c 6 s 10; 1994 c 465 art 3 s 52; 1994 c 625 art 8 s 72; 1995 c 178 art 2 s 26; 1995 c 207 art 6 s 38-51; art 8 s 33; 1995 c 234 art 6 s 38; 1995 c 263 s 10; 1996 c 451 art 2 s 20; art 5 s 15,16; 1997 c 203 art 2 s 25; art 4 s 25,26; 1997 c 225 art 4 s 3; art 6 s 5,8; 1998 c 398 art 2 s 46; 1998 c 407 art 4 s 20-28; 1999 c 86 art 2 s 4; 1999 c 139 art 4 s 2; 1999 c 245 art 4 s 37-49,121; art 5 s 20; art 8 s 5,87; art 10 s 10; 2000 c 298 s 3; 2000 c 347 s 1; 2000 c 474 s 6,7; 2000 c 488 art 9 s 16; 2001 c 178 art 1 s 44; 2001 c 203 s 9; 1Sp2001 c 9 art 2 s 30-38; art 3 s 16-19; art 9 s 41,42; 2002 c 220 art 15 s 13; 2002 c 277 s 12-14,32; 2002 c 294 s 6; 2002 c 375 art 2 s 13-16; 2002 c 379 art 1 s 113; 2003 c 112 art 2 s 50; 1Sp2003 c 14 art 3 s 25; art 4 s 4-7; art 11 s 11; art 12 s 33-36; 2004 c 288 art 5 s 3; art 6 s 22; 2005 c 10 art 1 s 48; 2005 c 56 s 1; 2005 c 98 art 2 s 3,4; 2005 c 147 art 1 s 67; 2005 c 155 art 3 s 2-6; 1Sp2005 c 4 art 2 s 8-10; art 7 s 13,14; art 8 s 29-40; 2006 c 282 art 16 s 6; 2007 c 147 art 4 s 5-7; art 5 s 9; art 6 s 18; art 7 s 6,7; art 8 s 19-21; art 11 s 17; art 15 s 16; art 16 s 16; 2008 c 326 art 1 s 29-32; 2008 c 363 art 15 s 4; art 17 s 9; 2009 c 79 art 5 s 25-36; art 7 s 18,20; art 8 s 18-21; 2009 c 101 art 2 s 109; 2009 c 159 s 89; 2009 c 167 s 13; 2009 c 173*

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art 1 s 20,21,41; art 3 s 9,10; 2010 c 200 art 1 s 4,5; 2010 c 303 s 4; 2010 c 307 s 1; 2010 c 310 art 1 s 1; art 6 s 2; art 7 s 1; art 8 s 1; art 9 s 1; art 10 s 1; art 11 s 1; art 12 s 1,2; 2010 c 352 art 1 s 7; 1Sp2010 c 1 art 16 s 8-15; art 24 s 4; 2011 c 76 art 1 s 37; 2011 c 86 s 17,18; 1Sp2011 c 9 art 6 s 28-48; art 7 s 8; art 8 s 6; 1Sp2011 c 11 art 3 s 12; 2012 c 169 s 1; 2012 c 181 s 1; 2012 c 187 art 3 s 12; 2012 c 216 art 9 s 11; art 11 s 1; art 12 s 8; art 13 s 7-11; 2012 c 247 art 1 s 3-9,27; 2013 c 81 s 4-10; 2013 c 108 art 4 s 17-20; art 6 s 8-16; art 9 s 10; 2013 c 125 art 1 s 107; 2014 c 262 art 5 s 6; 2014 c 275 art 1 s 58; 2014 c 286 art 7 s 8,13; art 8 s 31; 2014 c 291 art 9 s 1,5; 2014 c 311 s 18; 2014 c 312 art 24 s 28-35

NOTE: Subdivision 16 was found unconstitutional with regard to public funding for medical services related to therapeutic abortions. Women of State of Minn. by Doe v. Gomez, 542 N.W.2d 17 (Minn. 1995).

NOTE: Subdivision 28b, as added by Laws 2013, chapter 108, article 6, section 11, is effective July 1, 2014, or upon federal approval, whichever is later, and applies to services provided on or after the effective date. Laws 2013, chapter 108, article 6, section 11, the effective date.

NOTE: Subdivision 50 as added by Laws 2007, chapter 147, article 7, section 7, is effective upon federal approval of the state Medicaid plan amendment. Laws 2007, chapter 147, article 7, section 7, the effective date.

NOTE: Subdivision 53, as added by Laws 2009, chapter 173, article 3, section 10, is effective August 1, 2009, or upon federal approval, whichever is later. Laws 2009, chapter 173, article 3, section 10, the effective date.

256B.0626 ESTIMATION OF 50TH PERCENTILE OF PREVAILING CHARGES.

(a) The 50th percentile of the prevailing charge for the base year identified in statute must be estimated by the commissioner in the following situations:

(1) there were less than five billings in the calendar year specified in legislation governing maximum payment rates;

(2) the service was not available in the calendar year specified in legislation governing maximum payment rates;

(3) the payment amount is the result of a provider appeal;

(4) the procedure code description has changed since the calendar year specified in legislation governing maximum payment rates, and, therefore, the prevailing charge information reflects the same code but a different procedure description; or

(5) the 50th percentile reflects a payment which is grossly inequitable when compared with payment rates for procedures or services which are substantially similar.

(b) When one of the situations identified in paragraph (a) occurs, the commissioner shall use the following methodology to reconstruct a rate comparable to the 50th percentile of the prevailing rate:

(1) refer to information which exists for the first four billings in the calendar year specified in legislation governing maximum payment rates; or

(2) refer to surrounding or comparable procedure codes; or

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(3) refer to the 50th percentile of years subsequent to the calendar year specified in legislation governing maximum payment rates, and reduce that amount by applying an appropriate Consumer Price Index formula; or

(4) refer to relative value indexes; or

(5) refer to reimbursement information from other third parties, such as Medicare.

History: *1Sp1993 c 1 art 5 s 50; 1997 c 203 art 4 s 27*

256B.0627 Subdivision 1. [Paragraph (a) renumbered 256B.0651, subdivision 1; 256B.0655, subd 1a]

[Paragraph (b) renumbered 256B.0651, subdivision 1, para (b); 256B.0654, subdivision 1, para (a); 256B.0655, subd 1b]

[Paragraph (c) renumbered 256B.0655, subd 1c]

[Paragraph (d) renumbered 256B.0654, subdivision 1, para (b)]

[Paragraph (e) renumbered 256B.0655, subd 1d]

[Paragraph (f) renumbered 256B.0651, subdivision 1, para (c)]

Paragraph (g) renumbered 256B.0655, subd 1e

[Paragraph (h) renumbered 256B.0651, subdivision 1, para (d)]

[Paragraph (i) renumbered 256B.0655, subd 1f]

[Paragraph (j) renumbered 256B.0655, subd 1g]

[Paragraph (k) renumbered 256B.0655, subd 1h]

[Paragraph (l) renumbered 256B.0655, subd 1i]

[Paragraph (m) renumbered 256B.0653, subdivision 1]

[Paragraph (n) renumbered 256B.0651, subdivision 1, para (e)]

Subd. 2. [Renumbered 256B.0651, subd 2]

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

Subd. 4. [Renumbered 256B.0655, subd 2]

Subd. 5. [Paragraph (a) renumbered 256B.0651, subds 10 and 11]

[Paragraph (b) renumbered 256B.0651, subd 4]

[Paragraph (c) renumbered 256B.0651, subd 5]

[Paragraph (d) renumbered 256B.0655, subd 3]

[Paragraph (e) renumbered 256B.0651, subd 6; 256B.0655, subd 4]

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[Paragraph (e)(1) renumbered 256B.0651, subd 6]

[Paragraph (e)(2) renumbered 256B.0655, subd 4]

[Paragraph (e)(3) renumbered 256B.0654, subd 2]

[Paragraph (e)(4) renumbered 256B.0651, subd 6, para (b)]

[Paragraph (f) renumbered 256B.0651, subd 7]

[Paragraph (g) renumbered 256B.0651, subd 12]

[Paragraph (h) renumbered 256B.0651, subd 8]

[Paragraph (i) renumbered 256B.0651, subd 9]

Subd. 6. [Renumbered 256B.0651, subd 13]

Subd. 7. [Renumbered 256B.0651, subd 3]

Subd. 8. [Renumbered 256B.0655, subd 5]

Subd. 9. [Renumbered 256B.0655, subd 6]

Subd. 10. [Renumbered 256B.0655, subd 7]

Subd. 11. [Renumbered 256B.0654, subd 3]

Subd. 12. [Renumbered 256B.0655, subd 8]

Subd. 13. [Renumbered 256B.0656]

Subd. 14. [Renumbered 256B.0653, subd 2]

Subd. 15. [Renumbered 256B.0653, subd 3]

Subd. 16. [Renumbered 256B.0654, subd 4]

Subd. 17. [Renumbered 256B.0655, subd 9]

Subd. 18. [Renumbered 256B.0655, subd 10]

256B.0628 [Renumbered 256B.0652]

256B.0629 Subdivision 1. [Repealed, 2005 c 98 art 2 s 18]

Subd. 2. [Repealed, 2005 c 98 art 2 s 18]

Subd. 3. [Repealed, 1997 c 7 art 2 s 67]

Subd. 4. [Repealed, 2005 c 98 art 2 s 18]

256B.063 COST SHARING.

Notwithstanding the provisions of section 256B.05, subdivision 2, the commissioner is authorized to promulgate rules pursuant to the Administrative Procedure Act, and to require a nominal enrollment fee, premium, or similar charge for recipients of medical assistance, if and to the extent required by applicable federal regulation.

History: *1973 c 717 s 5*

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256B.0631 MEDICAL ASSISTANCE CO-PAYMENTS.

Subdivision 1. **Cost-sharing.** (a) Except as provided in subdivision 2, the medical assistance benefit plan shall include the following cost-sharing for all recipients, effective for services provided on or after September 1, 2011:

(1) $3 per nonpreventive visit, except as provided in paragraph (b). For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

(2) $3.50 for nonemergency visits to a hospital-based emergency room, except that this co-payment shall be increased to $20 upon federal approval;

(3) $3 per brand-name drug prescription and $1 per generic drug prescription, subject to a $12 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness;

(4) effective January 1, 2012, a family deductible equal to the maximum amount allowed under Code of Federal Regulations, title 42, part 447.54; and

(5) for individuals identified by the commissioner with income at or below 100 percent of the federal poverty guidelines, total monthly cost-sharing must not exceed five percent of family income. For purposes of this paragraph, family income is the total earned and unearned income of the individual and the individual's spouse, if the spouse is enrolled in medical assistance and also subject to the five percent limit on cost-sharing.

(b) Recipients of medical assistance are responsible for all co-payments and deductibles in this subdivision.

(c) Notwithstanding paragraph (b), the commissioner, through the contracting process under sections 256B.69 and 256B.692, may allow managed care plans and county-based purchasing plans to waive the family deductible under paragraph (a), clause (4). The value of the family deductible shall not be included in the capitation payment to managed care plans and county-based purchasing plans. Managed care plans and county-based purchasing plans shall certify annually to the commissioner the dollar value of the family deductible.

(d) Notwithstanding paragraph (b), the commissioner may waive the collection of the family deductible described under paragraph (a), clause (4), from individuals and allow long-term care and waivered service providers to assume responsibility for payment.

(e) Notwithstanding paragraph (b), the commissioner, through the contracting process under section 256B.0756 shall allow the pilot program in Hennepin County to waive co-payments. The value of the co-payments shall not be included in the capitation payment amount to the integrated health care delivery networks under the pilot program.

Subd. 2. **Exceptions.** Co-payments and deductibles shall be subject to the following exceptions:

(1) children under the age of 21;

(2) pregnant women for services that relate to the pregnancy or any other medical condition that may complicate the pregnancy;

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(3) recipients expected to reside for at least 30 days in a hospital, nursing home, or intermediate care facility for the developmentally disabled;

(4) recipients receiving hospice care;

(5) 100 percent federally funded services provided by an Indian health service;

(6) emergency services;

(7) family planning services;

(8) services that are paid by Medicare, resulting in the medical assistance program paying for the coinsurance and deductible;

(9) co-payments that exceed one per day per provider for nonpreventive visits, eyeglasses, and non-emergency visits to a hospital-based emergency room; and

(10) services, fee-for-service payments subject to volume purchase through competitive bidding.

Subd. 3. **Collection.** (a) The medical assistance reimbursement to the provider shall be reduced by the amount of the co-payment or deductible, except that reimbursements shall not be reduced:

(1) once a recipient has reached the $12 per month maximum for prescription drug co-payments; or

(2) for a recipient identified by the commissioner under 100 percent of the federal poverty guidelines who has met their monthly five percent cost-sharing limit.

(b) The provider collects the co-payment or deductible from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment or deductible.

(c) Medical assistance reimbursement to fee-for-service providers and payments to managed care plans shall not be increased as a result of the removal of co-payments or deductibles effective on or after January 1, 2009.

Subd. 4. MS 2006 [Repealed, 2007 c 147 art 5 s 41]

History: *1Sp2003 c 14 art 12 s 37; 2005 c 56 s 1; 1Sp2005 c 4 art 8 s 41,42; 2007 c 147 art 5 s 10,11,41; 2008 c 363 art 17 s 10,11; 1Sp2010 c 1 art 16 s 16,17; 1Sp2011 c 9 art 6 s 49-51; 2012 c 216 art 13 s 12,13; 2012 c 247 art 1 s 10; 2013 c 108 art 6 s 17*

256B.0635 CONTINUED ELIGIBILITY IN SPECIAL CIRCUMSTANCES.

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

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it has been determined that the person is not otherwise eligible for medical assistance. Medical assistance may be continued for an additional six months if the person meets all requirements for the additional six months, according to title XIX of the Social Security Act, as amended by section 303 of the Family Support Act of 1988, Public Law 100-485.

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

Subd. 2. **Increased child or spousal support.** (a) Until June 30, 2002, medical assistance may be paid for persons who received MFIP or medical assistance for families and children in at least three of the six months preceding the month in which the person became ineligible for MFIP or medical assistance, if the ineligibility was the result of the collection of child or spousal support under part D of title IV of the Social Security Act. In addition, to receive continued assistance under this section, persons who received medical assistance for families and children but did not receive MFIP must have had income less than or equal to the assistance standard for their family size under the state's AFDC plan in effect as of July 16, 1996, increased by three percent effective July 1, 2000, at the time medical assistance eligibility began. A person who is eligible for extended medical assistance under this subdivision is entitled to four months of assistance without reapplication, unless the assistance unit ceases to include a dependent child, except medical assistance may not be discontinued for that dependent child under 21 years of age within the four-month period of extended eligibility until it has been determined that the person is not otherwise eligible for medical assistance.

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

Subd. 3. [Repealed, 2002 c 277 s 34]

History: *1997 c 85 art 3 s 22; 1998 c 407 art 6 s 13; 1999 c 245 art 4 s 59; 1Sp2001 c 9 art 2 s 40,41,76; art 10 s 66; 2002 c 277 s 31,33; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 12 s 38,39*

256B.0636 CONTROLLED SUBSTANCE PRESCRIPTIONS; ABUSE PREVENTION.

The commissioner of human services shall develop and implement a plan to:

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(1) review utilization patterns of Minnesota health care program enrollees for controlled substances listed in section 152.02, subdivisions 3 and 4, and those substances defined by the Board of Pharmacy under section 152.02, subdivisions 8 and 12;

(2) develop a mechanism to address abuses both for fee-for-service Minnesota health care program enrollees and those enrolled in managed care plans; and

(3) provide education to Minnesota health care program enrollees on the proper use of controlled substances.

For purposes of this section, "Minnesota health care program" means medical assistance, MinnesotaCare, or general assistance medical care.

History: *2007 c 147 art 12 s 11*

256B.0637 PRESUMPTIVE ELIGIBILITY; TREATMENT FOR BREAST OR CERVICAL CANCER.

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

History: *1Sp2001 c 9 art 2 s 42; 2002 c 379 art 1 s 113*

256B.064 SANCTIONS; MONETARY RECOVERY.

Subdivision 1. **Terminating payments to ineligible vendors.** The commissioner may terminate payments under this chapter to any person or facility that, under applicable federal law or regulation, has been determined to be ineligible for payments under title XIX of the Social Security Act.

Subd. 1a. **Grounds for sanctions against vendors.** The commissioner may impose sanctions against a vendor of medical care for any of the following: (1) fraud, theft, or abuse in connection with the provision of medical care to recipients of public assistance; (2) a pattern of presentment of false or duplicate claims or claims for services not medically necessary; (3) a pattern of making false statements of material facts for the purpose of obtaining greater compensation than that to which the vendor is legally entitled; (4) suspension or termination as a Medicare vendor; (5) refusal to grant the state agency access during regular business hours to examine all records necessary to disclose the extent of services provided to program recipients and appropriateness of claims for payment; (6) failure to repay an overpayment or a fine finally established under this section; (7) failure to correct errors in the maintenance of health service or financial records for which a fine was imposed or after issuance of a warning by the commissioner; and (8) any reason for which a vendor could be excluded from participation in the Medicare program under section 1128, 1128A, or 1866(b)(2) of the Social Security Act.

Subd. 1b. **Sanctions available.** The commissioner may impose the following sanctions for the conduct described in subdivision 1a: suspension or withholding of payments to a vendor and suspending or ter-

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minating participation in the program, or imposition of a fine under subdivision 2, paragraph (f). When imposing sanctions under this section, the commissioner shall consider the nature, chronicity, or severity of the conduct and the effect of the conduct on the health and safety of persons served by the vendor. Regardless of imposition of sanctions, the commissioner may make a referral to the appropriate state licensing board.

Subd. 1c. **Grounds for and methods of monetary recovery.** (a) The commissioner may obtain monetary recovery from a vendor who has been improperly paid either as a result of conduct described in subdivision 1a or as a result of a vendor or department error, regardless of whether the error was intentional. Patterns need not be proven as a precondition to monetary recovery of erroneous or false claims, duplicate claims, claims for services not medically necessary, or claims based on false statements.

(b) The commissioner may obtain monetary recovery using methods including but not limited to the following: assessing and recovering money improperly paid and debiting from future payments any money improperly paid. The commissioner shall charge interest on money to be recovered if the recovery is to be made by installment payments or debits, except when the monetary recovery is of an overpayment that resulted from a department error. The interest charged shall be the rate established by the commissioner of revenue under section 270C.40.

Subd. 1d. **Investigative costs.** The commissioner may seek recovery of investigative costs from any vendor of medical care or services who willfully submits a claim for reimbursement for services that the vendor knows, or reasonably should have known, is a false representation and that results in the payment of public funds for which the vendor is ineligible. Billing errors that result in unintentional overcharges shall not be grounds for investigative cost recoupment.

Subd. 2. **Imposition of monetary recovery and sanctions.** (a) The commissioner shall determine any monetary amounts to be recovered and sanctions to be imposed upon a vendor of medical care under this section. Except as provided in paragraphs (b) and (d), neither a monetary recovery nor a sanction will be imposed by the commissioner without prior notice and an opportunity for a hearing, according to chapter 14, on the commissioner's proposed action, provided that the commissioner may suspend or reduce payment to a vendor of medical care, except a nursing home or convalescent care facility, after notice and prior to the hearing if in the commissioner's opinion that action is necessary to protect the public welfare and the interests of the program.

(b) Except when the commissioner finds good cause not to suspend payments under Code of Federal Regulations, title 42, section 455.23 (e) or (f), the commissioner shall withhold or reduce payments to a vendor of medical care without providing advance notice of such withholding or reduction if either of the following occurs:

(1) the vendor is convicted of a crime involving the conduct described in subdivision 1a; or

(2) the commissioner determines there is a credible allegation of fraud for which an investigation is pending under the program. A credible allegation of fraud is an allegation which has been verified by the state, from any source, including but not limited to:

(i) fraud hotline complaints;

(ii) claims data mining; and

(iii) patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

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Allegations are considered to be credible when they have an indicia of reliability and the state agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.

(c) The commissioner must send notice of the withholding or reduction of payments under paragraph (b) within five days of taking such action unless requested in writing by a law enforcement agency to temporarily withhold the notice. The notice must:

(1) state that payments are being withheld according to paragraph (b);

(2) set forth the general allegations as to the nature of the withholding action, but need not disclose any specific information concerning an ongoing investigation;

(3) except in the case of a conviction for conduct described in subdivision 1a, state that the withholding is for a temporary period and cite the circumstances under which withholding will be terminated;

(4) identify the types of claims to which the withholding applies; and

(5) inform the vendor of the right to submit written evidence for consideration by the commissioner.

The withholding or reduction of payments will not continue after the commissioner determines there is insufficient evidence of fraud by the vendor, or after legal proceedings relating to the alleged fraud are completed, unless the commissioner has sent notice of intention to impose monetary recovery or sanctions under paragraph (a).

(d) The commissioner shall suspend or terminate a vendor's participation in the program without providing advance notice and an opportunity for a hearing when the suspension or termination is required because of the vendor's exclusion from participation in Medicare. Within five days of taking such action, the commissioner must send notice of the suspension or termination. The notice must:

(1) state that suspension or termination is the result of the vendor's exclusion from Medicare;

(2) identify the effective date of the suspension or termination; and

(3) inform the vendor of the need to be reinstated to Medicare before reapplying for participation in the program.

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

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

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

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

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

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(5) other information required by the commissioner.

(f) The commissioner may order a vendor to forfeit a fine for failure to fully document services according to standards in this chapter and Minnesota Rules, chapter 9505. The commissioner may assess fines if specific required components of documentation are missing. The fine for incomplete documentation shall equal 20 percent of the amount paid on the claims for reimbursement submitted by the vendor, or up to $5,000, whichever is less.

(g) The vendor shall pay the fine assessed on or before the payment date specified. If the vendor fails to pay the fine, the commissioner may withhold or reduce payments and recover the amount of the fine. A timely appeal shall stay payment of the fine until the commissioner issues a final order.

History: *1973 c 717 s 6; 1976 c 188 s 1; 1980 c 349 s 5,6; 1982 c 424 s 130; 1983 c 312 art 5 s 17; 1987 c 370 art 1 s 4; 1987 c 403 art 2 s 81; 1988 c 629 s 52; 1991 c 292 art 5 s 29; 1992 c 513 art 7 s 51,52; 1997 c 203 art 4 s 30-32; 2000 c 400 s 1; 1Sp2003 c 14 art 2 s 17; 2005 c 151 art 2 s 17; 1Sp2011 c 9 art 6 s 52; 2013 c 108 art 5 s 8-10; 2014 c 286 art 7 s 9*

256B.0641 RECOVERY OF OVERPAYMENTS.

Subdivision 1. **Recovery procedures; sources.** Notwithstanding section 256B.72 or any law or rule to the contrary, when the commissioner or the federal government determines that an overpayment has been made by the state to any medical assistance vendor, the commissioner shall recover the overpayment as follows:

(1) if the federal share of the overpayment amount is due and owing to the federal government under federal law and regulations, the commissioner shall recover from the medical assistance vendor the federal share of the determined overpayment amount paid to that provider using the schedule of payments required by the federal government;

(2) if the overpayment to a medical assistance vendor is due to a retroactive adjustment made because the medical assistance vendor's temporary payment rate was higher than the established desk audit payment rate or because of a department error in calculating a payment rate, the commissioner shall recover from the medical assistance vendor the total amount of the overpayment within 120 days after the date on which written notice of the adjustment is sent to the medical assistance vendor or according to a schedule of payments approved by the commissioner;

(3) a medical assistance vendor is liable for the overpayment amount owed by a long-term care provider if the vendors or their owners are under common control or ownership; and

(4) in order to collect past due obligations to the department, the commissioner shall make any necessary adjustments to payments to a provider or vendor that has the same tax identification number as is assigned to a provider or vendor with past due obligations.

Subd. 2. **Overpayments to prior owners.** The current owner of a nursing home, boarding care home, or intermediate care facility for persons with developmental disabilities is liable for the overpayment amount owed by a former owner for any facility sold, transferred, or reorganized after May 15, 1987. Within 12 months of a written request by the current owner, the commissioner shall conduct a field audit of the facility for the auditable rate years during which the former owner owned the facility and issue a report of the field audit within 15 months of the written request. Nothing in this subdivision limits the liability of a former owner.

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Subd. 3. **Facility in receivership.** Subdivision 2 does not apply to the change of ownership of a facility to a nonrelated organization while the facility to be sold, transferred or reorganized is in receivership under section 144A.14, 144A.15, 245A.12, or 245A.13, and the commissioner during the receivership has not determined the need to place residents of the facility into a newly constructed or newly established facility. Nothing in this subdivision limits the liability of a former owner.

History: *1Sp1985 c 9 art 2 s 39; 1987 c 133 s 1; 1991 c 292 art 6 s 46; 1995 c 207 art 7 s 22; 2005 c 56 s 1; 2009 c 79 art 8 s 22; 1Sp2011 c 9 art 6 s 53*

256B.0642 FEDERAL FINANCIAL PARTICIPATION.

The commissioner may, in the aggregate, prospectively reduce payment rates for medical assistance providers receiving federal funds to avoid reduced federal financial participation resulting from rates that are in excess of the Medicare limitations.

History: *1989 c 282 art 3 s 59*

256B.0643 VENDOR REQUEST FOR CONTESTED CASE PROCEEDING.

Unless otherwise provided by law, a vendor of medical care, as defined in section 256B.02, subdivision 7, must use this procedure to request a contested case, as defined in section 14.02, subdivision 3. A request for a contested case must be filed with the commissioner in writing within 60 days after the date the notification of an action or determination was mailed. The appeal request must specify:

(1) each disputed action or item;

(2) the reason for the dispute;

(3) an estimate of the dollar amount involved, if any, for each disputed item;

(4) the computation or other disposition that the appealing party believes is correct;

(5) the authority in statute or rule upon which the appealing party relies for each disputed item;

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

(7) other information required by the commissioner. Nothing in this section shall be construed to create a right to an administrative appeal or contested case proceeding.

History: *1990 c 568 art 3 s 53*

256B.0644 REIMBURSEMENT UNDER OTHER STATE HEALTH CARE PROGRAMS.

(a) 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 and MinnesotaCare as a condition of participating as a provider in health insurance plans and programs or contractor for state employees established under section 43A.18, the public employees insurance program under section 43A.316, for health insurance plans offered to local statutory or home rule charter city, county, and school district employees, the workers' compensation system under section 176.135, and insurance plans provided through the Minnesota Comprehensive Health Association under sections 62E.01 to 62E.19. The limitations on insurance plans offered to local government employees shall

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not be applicable in geographic areas where provider participation is limited by managed care contracts with the Department of Human Services.

(b) For providers other than health maintenance organizations, participation in the medical assistance program means that:

(1) the provider accepts new medical assistance and MinnesotaCare patients;

(2) for providers other than dental service providers, at least 20 percent of the provider's patients are covered by medical assistance and MinnesotaCare as their primary source of coverage; or

(3) for dental service providers, at least ten percent of the provider's patients are covered by medical assistance and MinnesotaCare as their primary source of coverage, or the provider accepts new medical assistance and MinnesotaCare patients who are children with special health care needs. For purposes of this section, "children with special health care needs" means children up to age 18 who: (i) require health and related services beyond that required by children generally; and (ii) have or are at risk for a chronic physical, developmental, behavioral, or emotional condition, including: bleeding and coagulation disorders; immunodeficiency disorders; cancer; endocrinopathy; developmental disabilities; epilepsy, cerebral palsy, and other neurological diseases; visual impairment or deafness; Down syndrome and other genetic disorders; autism; fetal alcohol syndrome; and other conditions designated by the commissioner after consultation with representatives of pediatric dental providers and consumers.

(c) Patients seen on a volunteer basis by the provider at a location other than the provider's usual place of practice may be considered in meeting the participation requirement in this section. 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 management and budget, 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 management and budget shall implement this section through contracts with participating health and dental carriers.

(d) A volunteer dentist who has signed a volunteer agreement under section 256B.0625, subdivision 9a, shall not be considered to be participating in medical assistance or MinnesotaCare for the purpose of this section.

History: *1992 c 549 art 4 s 13; 1993 c 13 art 2 s 7; 1993 c 247 art 4 s 9; 1993 c 339 s 14; 1993 c 345 art 9 s 14; 1995 c 248 art 10 s 16; 1997 c 203 art 4 s 33,72; 1999 c 177 s 87; 1Sp2001 c 9 art 2 s 43; 2002 c 275 s 3; 2002 c 379 art 1 s 113; 2007 c 147 art 5 s 12; 2008 c 204 s 42; 2009 c 101 art 2 s 109; 2010 c 200 art 1 s 6; 1Sp2010 c 1 art 16 s 18; 2012 c 181 s 2*

256B.0645 PROVIDER PAYMENTS; RETROACTIVE CHANGES IN ELIGIBILITY.

Payment to a provider for a health care service provided to a general assistance medical care recipient who is later determined eligible for medical assistance or MinnesotaCare according to section 256L.03, subdivision 1a, for the period in which the health care service was provided, may be adjusted due to the change in eligibility. This section does not apply to payments made to health plans on a prepaid capitated basis.

History: *1995 c 234 art 6 s 39; 1998 c 407 art 4 s 32*

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256B.065 SOCIAL SECURITY AMENDMENTS.

The commissioner shall comply with requirements of the Social Security amendments of 1972 (Public Law 92-603) necessary in order to avoid loss of federal funds, and shall implement by rule, pursuant to the Administrative Procedure Act, those provisions required of state agencies supervising Title XIX of the Social Security Act.

History: *1973 c 717 s 7*

256B.0651 HOME CARE SERVICES.

Subdivision 1. **Definitions.** (a) For the purposes of sections 256B.0651 to 256B.0654 and 256B.0659, the terms in paragraphs (b) to (g) have the meanings given.

(b) "Activities of daily living" has the meaning given in section 256B.0659, subdivision 1, paragraph (b).

(c) "Assessment" means a review and evaluation of a recipient's need for home care services conducted in person.

(d) "Home care services" means medical assistance covered services that are home health agency services, including skilled nurse visits; home health aide visits; physical therapy, occupational therapy, respiratory therapy, and language-speech pathology therapy; home care nursing; and personal care assistance.

(e) "Home residence," effective January 1, 2010, means a residence owned or rented by the recipient either alone, with roommates of the recipient's choosing, or with an unpaid responsible party or legal representative; or a family foster home where the license holder lives with the recipient and is not paid to provide home care services for the recipient except as allowed under sections 256B.0652, subdivision 10, and 256B.0654, subdivision 4.

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

(g) "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 on a ventilator for at least 30 consecutive days.

Subd. 2. **Services covered.** Home care services covered under this section and sections 256B.0652 to 256B.0654 and 256B.0659 include:

(1) nursing services under sections 256B.0625, subdivision 6a, and 256B.0653;

(2) home care nursing services under sections 256B.0625, subdivision 7, and 256B.0654;

(3) home health services under sections 256B.0625, subdivision 6a, and 256B.0653;

(4) personal care assistance services under sections 256B.0625, subdivision 19a, and 256B.0659;

(5) supervision of personal care assistance services provided by a qualified professional under sections 256B.0625, subdivision 19a, and 256B.0659;

(6) face-to-face assessments by county public health nurses for services under sections 256B.0625, subdivision 19a, and 256B.0659; and

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(7) service updates and review of temporary increases for personal care assistance services by the county public health nurse for services under sections 256B.0625, subdivision 19a, and 256B.0659.

Subd. 3. **Noncovered home care services.** The following home care services are not eligible for payment under medical assistance:

(1) services provided in a nursing facility, hospital, or intermediate care facility with exceptions in section 256B.0653;

(2) services for the sole purpose of monitoring medication compliance with an established medication program for a recipient;

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

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

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

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

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

Subd. 4. MS 2008 [Renumbered 256B.0652, subd 14]

Subd. 5. [Repealed by amendment, 2009 c 79 art 8 s 23]

Subd. 6. MS 2008 [Paragraph (a) renumbered 256B.0652, subd 3a]

[Paragraph (b) renumbered 256B.0652, subd 4]

[Paragraph (c) renumbered 256B.0652, subd 7]

Subd. 7. MS 2008 [Paragraph (a) renumbered 256B.0652, subd 8]

[Paragraph (b) renumbered 256B.0652, subd 8]

[Paragraph (c) renumbered 256B.0652, subd 13]

Subd. 8. MS 2008 [Renumbered 256B.0652, subd 9]

Subd. 9. MS 2008 [Renumbered 256B.0652, subd 10]

Subd. 10. [Repealed by amendment, 2009 c 79 art 8 s 23]

Subd. 11. MS 2008 [Renumbered 256B.0652, subd 11]

Subd. 12. **Approval of home care services.** The commissioner or the commissioner's designee shall determine the medical necessity of home care services, the level of caregiver according to subdivision 2, and the institutional comparison according to this subdivision and sections 256B.0652, subdivisions 3a, 4 to 11,

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13, and 14, and 256B.0659, 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.

Subd. 13. **Recovery of excessive payments.** The commissioner shall seek monetary recovery from providers of payments made for services which exceed the limits established in this section and sections 256B.0653, 256B.0654, and 256B.0659. This subdivision does not apply to services provided to a recipient at the previously authorized level pending an appeal under section 256.045, subdivision 10.

Subd. 14. **Referrals to Medicare providers required.** Home care providers that do not participate in or accept Medicare assignment must refer and document the referral of dual-eligible recipients to Medicare providers when Medicare is determined to be the appropriate payer for services and supplies and equipment. Providers must be terminated from participation in the medical assistance program for failure to make these referrals.

Subd. 15. **Quality assurance for program integrity.** The commissioner shall establish an ongoing quality assurance process for home care services to monitor program integrity, including provider standards and training, consumer surveys, and random reviews of documentation.

Subd. 16. **Oversight of enrolled providers.** The commissioner has the authority to request proof of documentation of meeting provider standards, quality standards of care, correct billing practices, and other information. Failure to comply with or to provide access and information to demonstrate compliance with laws, rules, or policies may result in suspension, denial, or termination of the provider agency's enrollment with the department.

Subd. 17. **Recipient protection.** (a) Providers of home care services must provide each recipient with a copy of the home care bill of rights under section 144A.44 at least 30 days prior to terminating services to a recipient, if the termination results from provider sanctions under section 256B.064, such as a payment withhold, a suspension of participation, or a termination of participation. If a home care provider determines it is unable to continue providing services to a recipient, the provider must notify the recipient, the recipient's responsible party, and the commissioner 30 days prior to terminating services to the recipient because of an action under section 256B.064, and must assist the commissioner and lead agency in supporting the recipient in transitioning to another home care provider of the recipient's choice.

(b) In the event of a payment withhold from a home care provider, a suspension of participation, or a termination of participation of a home care provider under section 256B.064, the commissioner may inform the Office of Ombudsman for Long-Term Care and the lead agencies for all recipients with active service agreements with the provider. At the commissioner's request, the lead agencies must contact recipients to ensure that the recipients are continuing to receive needed care, and that the recipients have been given free choice of provider if they transfer to another home care provider. In addition, the commissioner or the commissioner's delegate may directly notify recipients who receive care from the provider that payments have been withheld or that the provider's participation in medical assistance has been suspended or terminated, if the commissioner determines that notification is necessary to protect the welfare of the recipients. For purposes of this subdivision, "lead agencies" means counties, tribes, and managed care organizations.

History: *1986 c 444; 1990 c 568 art 3 s 51; 1991 c 292 art 7 s 12,25; 1992 c 391 s 3-6; 1992 c 464 art 2 s 1; 1992 c 513 art 7 s 50; 1Sp1993 c 1 art 5 s 51-53; 1995 c 207 art 6 s 52-55; 1996 c 451 art 5 s*

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17-20; 1997 c 203 art 4 s 28,29; 3Sp1997 c 3 s 9; 1998 c 407 art 4 s 29-31; 1999 c 245 art 4 s 50-58; 2000 c 474 s 8-11; 1Sp2001 c 9 art 3 s 29-41; 2002 c 375 art 2 s 17; 2002 c 379 art 1 s 113; 2003 c 15 art 1 s 33; 1Sp2003 c 14 art 3 s 26-28; 2005 c 10 art 1 s 49,50; 2005 c 56 s 1; 1Sp2005 c 4 art 7 s 15-19; 2007 c 147 art 7 s 8; 2009 c 79 art 8 s 23,85; 2010 c 352 art 1 s 8; 2014 c 262 art 5 s 6; 2014 c 291 art 9 s 5

256B.0652 AUTHORIZATION AND REVIEW OF HOME CARE SERVICES.

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

Subd. 2. **Duties.** (a) The commissioner may contract with or employ necessary staff, or contract with qualified agencies, to provide home care authorization and review services for medical assistance recipients who are receiving home care services.

(b) Reimbursement for the authorization function shall be made through the medical assistance administrative authority. The state shall pay the nonfederal share. The functions will be to:

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

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

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

(4) recommend the approval or denial of the use of medical assistance funds to pay for home care services;

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

(6) conduct on-site assessments when determined necessary by the commissioner and recommend changes to care plans that will provide more efficient and appropriate home care; and

(7) on the department's Web site:

(i) provide a link to MinnesotaHelp.info for a list of enrolled home care agencies with the following information: main office address, contact information for the agency, counties in which services are provided, type of home care services provided, whether the personal care assistance choice option is offered, types of qualified professionals employed, number of personal care assistants employed, and data on staff turnover; and

(ii) post data on home care services including information from both fee-for-service and managed care plans on recipients as available.

(c) In addition, the commissioner or the commissioner's designee may:

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

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

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

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

(5) assure the quality of home care services; and

(6) assure that all liable third-party payers including, but not limited to, Medicare have been used prior to medical assistance for home care services.

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

Subd. 3. MS 2008 [Renumbered subd 12]

Subd. 3a. **Authorization; generally.** The commissioner, or the commissioner's designee, shall review the assessment, 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 provided in this section.

Subd. 4. **Home health services.** Home health services including skilled nurse visits and home health aide visits must be authorized by the commissioner or the commissioner's designee. Authorization must be based on medical necessity and cost-effectiveness when compared with other care options. The commissioner must receive the request for authorization of skilled nurse visits and home health aide visits within 20 working days of the start of service. When home health services are used in combination with personal care and home care nursing, the cost of all home care services shall be considered for cost-effectiveness.

Subd. 5. **Authorization; home care nursing services.** (a) All home care nursing services shall be authorized by the commissioner or the commissioner's designee. Authorization for home care nursing services shall be based on medical necessity and cost-effectiveness when compared with alternative care options. The commissioner may authorize medically necessary home care nursing services in quarter-hour units when:

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

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

(b) The commissioner may authorize:

(1) 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;

(2) home care nursing in combination with other home care services up to the total cost allowed under this subdivision and subdivision 7;

(3) up to 16 hours per day if the recipient requires more nursing than the maximum number of direct care hours as established in clause (1) and, but for the provision of the nursing services, the recipient would require a hospital level of care as defined in Code of Federal Regulations, title 42, section 440.10.

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(c) The commissioner may authorize up to 16 hours per day of medically necessary home care nursing services or up to 24 hours per day of medically necessary home care 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 and sections 256B.0651, 256B.0653, and 256B.0659 than would otherwise be authorized under section 256B.49.

Subd. 6. **Authorization; personal care assistance and qualified professional.** (a) All personal care assistance services, supervision by a qualified professional, and additional services beyond the limits established in subdivision 11, must be authorized by the commissioner or the commissioner's designee before services begin except for the assessments established in subdivision 11 and section 256B.0911. The authorization for personal care assistance and qualified professional services under section 256B.0659 must be completed within 30 days after receiving a complete request.

(b) The amount of personal care assistance services authorized must be based on the recipient's home care rating. The home care rating shall be determined by the commissioner or the commissioner's designee based on information submitted to the commissioner identifying the following for recipients with dependencies in two or more activities of daily living:

(1) total number of dependencies of activities of daily living as defined in section 256B.0659;

(2) presence of complex health-related needs as defined in section 256B.0659; and

(3) presence of Level I behavior as defined in section 256B.0659.

(c) For purposes meeting the criteria in paragraph (b), the methodology to determine total time for personal care assistance services for each home care rating is based on the median paid units per day for each home care rating from fiscal year 2007 data for the personal care assistance program. Each home care rating has a base level of hours assigned. Additional time is added through the assessment and identification of the following:

(1) 30 additional minutes per day for a dependency in each critical activity of daily living as defined in section 256B.0659;

(2) 30 additional minutes per day for each complex health-related function as defined in section 256B.0659; and

(3) 30 additional minutes per day for each behavior issue as defined in section 256B.0659, subdivision 4, paragraph (d).

(d) Effective July 1, 2011, the home care rating for recipients who have a dependency in one activity of daily living or Level I behavior shall equal no more than two units per day. Recipients with this home care rating are not subject to the methodology in paragraph (c) and are not eligible for more than two units per day.

(e) A limit of 96 units of qualified professional supervision may be authorized for each recipient receiving personal care assistance services. A request to the commissioner to exceed this total in a calendar year must be requested by the personal care provider agency on a form approved by the commissioner.

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Subd. 7. **Ventilator-dependent.** 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 subdivision, home care services means all direct care services provided in the home that would be included in the payment for care at the long-term hospital. Recipients who meet the definition of ventilator dependent and the EN home care rating and utilize a combination of home care services are limited up to a total of 24 hours of home care services per day. Additional hours may be authorized when a recipient's assessment indicates a need for two staff to perform activities. Additional time is limited to four hours per day.

Subd. 8. **Authorization; time limits; amount and type.** (a) The commissioner or the commissioner's designee shall determine the time period for which an authorization shall be effective. If the recipient continues to require home care services beyond the duration of the authorization, the home care provider must request a new authorization. A personal care provider agency must request a new personal care assistance services assessment, or service update if allowed, at least 60 days prior to the end of the current authorization time period. The request for the assessment must be made on a form approved by the commissioner. An authorization must be valid for no more than 12 months.

(b) The amount and type of personal care assistance services authorized based upon the assessment and service plan must remain in effect for the recipient whether the recipient chooses a different provider or enrolls or disenrolls from a managed care plan under section 256B.0659, unless the service needs of the recipient change and new assessment is warranted under section 256B.0659, subdivision 3a.

Subd. 9. **Authorization requests; temporary services.** The agency nurse, independently enrolled home care nurse, or county public health nurse may request a temporary authorization for home care services. 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. The level of services authorized under this provision shall have no bearing on a future authorization.

Subd. 10. **Authorization for foster care setting.** (a) Home care services provided in an adult or child foster care setting must receive authorization by the commissioner according to the limits established in subdivision 11.

(b) The commissioner may not authorize:

(1) home care services that are the responsibility of the foster care provider under the terms of the foster care placement agreement, difficulty of care rate as of January 1, 2010, and administrative rules;

(2) personal care assistance services when the foster care license holder is also the personal care provider or personal care assistant, unless the foster home is the licensed provider's primary residence as defined in section 256B.0625, subdivision 19a; or

(3) personal care assistant and home care nursing services when the licensed capacity is greater than four.

Subd. 11. **Limits on services without 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 assistance services;

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

(3) up to nine face-to-face skilled nurse visits.

Subd. 12. **Assessment and authorization process for persons receiving personal care assistance and developmental disabilities services.** For purposes of providing informed choice, coordinating of local planning decisions, and streamlining administrative requirements, the assessment and authorization process for persons receiving both home care and home and community-based waivered services for persons with developmental disabilities shall meet the requirements of sections 256B.0651 to 256B.0654 and 256B.0659 with the following exceptions:

(a) Upon request for home care services and subsequent assessment by the public health nurse under sections 256B.0651 to 256B.0654 and 256B.0659, the public health nurse shall participate in the screening process, as appropriate, and, if home care services are determined to be necessary, participate in the development of a service plan coordinating the need for home care and home and community-based waivered services with the assigned county case manager, the recipient of services, and the recipient's legal representative, if any.

(b) The public health nurse shall give authorization for home care services to the extent that home care services are:

(1) medically necessary;

(2) chosen by the recipient and their legal representative, if any, from the array of home care and home and community-based waivered services available;

(3) coordinated with other services to be received by the recipient as described in the service plan; and

(4) provided within the county's reimbursement limits for home care and home and community-based waivered services for persons with developmental disabilities.

(c) If the public health agency is or may be the provider of home care services to the recipient, the public health agency shall provide the commissioner of human services with a written plan that specifies how the assessment and authorization process will be held separate and distinct from the provision of services.

Subd. 13. **Reduction of services; appeal.** A recipient who appeals a reduction in previously authorized home care services may continue previously authorized services, other than temporary services under subdivision 9, pending an appeal under section 256.045. The commissioner must ensure that the recipient has a copy of the most recent service plan that contains a detailed explanation of which areas of covered personal care assistance tasks are reduced, and provide notice of the amount of time per day reduced, and the reasons for the reduction in the recipient's notice of denial, termination, or reduction.

Subd. 14. **Authorization; exceptions.** All home care services above the limits in subdivision 11 must receive the commissioner's authorization before services begin, except when:

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

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(2) a recipient's medical assistance eligibility has lapsed, is then retroactively reinstated, and an authorization for home care services is completed based on the date of a current assessment, eligibility, and request for authorization;

(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) if a recipient enrolled in managed care experiences a temporary disenrollment from a health plan, the commissioner shall accept the current health plan authorization for personal care assistance services for up to 60 days. The request must be received within the first 30 days of the disenrollment. If the recipient's reenrollment in managed care is after the 60 days and before 90 days, the provider shall request an additional 30-day extension of the current health plan authorization, for a total limit of 90 days from the time of disenrollment.

History: *1991 c 292 art 7 s 13; 1Sp1993 c 1 art 5 s 54; 1995 c 207 art 3 s 18; art 6 s 56; 1996 c 451 art 2 s 21; 2005 c 56 s 1; 1986 c 444; 1990 c 568 art 3 s 51; 1991 c 292 art 7 s 12,25; 1992 c 391 s 3-6; 1992 c 464 art 2 s 1; 1992 c 513 art 7 s 50; 1Sp1993 c 1 art 5 s 51-53; 1995 c 207 art 6 s 52-55; 1996 c 451 art 5 s 17-20; 1997 c 203 art 4 s 28,29; 3Sp1997 c 3 s 9; 1998 c 407 art 4 s 29-31; 1999 c 245 art 4 s 50-58; 2000 c 474 s 8-11; 1Sp2001 c 9 art 3 s 29-41; 2002 c 375 art 2 s 17; 2002 c 379 art 1 s 113; 2003 c 15 art 1 s 33; 1Sp2003 c 14 art 3 s 26-28; 2005 c 10 art 1 s 49,50; 2005 c 56 s 1; 1Sp2005 c 4 art 7 s 15-19; 2007 c 147 art 6 s 19-22; art 7 s 8,9-11; 2008 c 286 art 1 s 7; 2009 c 79 art 6 s 9; art 8 s 23,24,26-28,85; 2009 c 173 art 1 s 22; 2010 c 352 art 1 s 9; 1Sp2011 c 9 art 7 s 9; 2013 c 63 s 7; 2014 c 262 art 5 s 6; 2014 c 291 art 9 s 5*

256B.0653 HOME HEALTH AGENCY SERVICES.

Subdivision 1. **Scope.** This section applies to home health agency services including home health aide, skilled nursing visits, physical therapy, occupational therapy, respiratory therapy, and speech-language pathology therapy.

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

(a) "Assessment" means an evaluation of the recipient's medical need for home health agency services by a registered nurse or appropriate therapist that is conducted within 30 days of a request.

(b) "Home care therapies" means occupational, physical, and respiratory therapy and speech-language pathology services provided in the home by a Medicare certified home health agency.

(c) "Home health agency services" means services delivered in the recipient's home residence, except as specified in section 256B.0625, by a home health agency to a recipient with medical needs due to illness, disability, or physical conditions.

(d) "Home health aide" means an employee of a home health agency who completes medically oriented tasks written in the plan of care for a recipient.

(e) "Home health agency" means a home care provider agency that is Medicare-certified.

(f) "Occupational therapy services" mean the services defined in Minnesota Rules, part 9505.0390.

(g) "Physical therapy services" mean the services defined in Minnesota Rules, part 9505.0390.

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(h) "Respiratory therapy services" mean the services defined in chapter 147C and Minnesota Rules, part 4668.0003, subpart 37.

(i) "Speech-language pathology services" mean the services defined in Minnesota Rules, part 9505.0390.

(j) "Skilled nurse visit" means a professional nursing visit to complete nursing tasks required due to a recipient's medical condition that can only be safely provided by a professional nurse to restore and maintain optimal health.

(k) "Store-and-forward technology" means telehomecare services that do not occur in real time via synchronous transmissions such as diabetic and vital sign monitoring.

(l) "Telehomecare" means the use of telecommunications technology via live, two-way interactive audiovisual technology which may be augmented by store-and-forward technology.

(m) "Telehomecare skilled nurse visit" means a visit by a professional nurse to deliver a skilled nurse visit to a recipient located at a site other than the site where the nurse is located and is used in combination with face-to-face skilled nurse visits to adequately meet the recipient's needs.

Subd. 3. **Home health aide visits.** (a) Home health aide visits must be provided by a certified home health aide using a written plan of care that is updated in compliance with Medicare regulations. A home health aide shall provide hands-on personal care, perform simple procedures as an extension of therapy or nursing services, and assist in instrumental activities of daily living as defined in section 256B.0659, including assuring that the person gets to medical appointments if identified in the written plan of care. Home health aide visits must be provided in the recipient's home.

(b) All home health aide visits must have authorization under section 256B.0652. The commissioner shall limit home health aide visits to no more than one visit per day per recipient.

(c) Home health aides must be supervised by a registered nurse or an appropriate therapist when providing services that are an extension of therapy.

Subd. 4. **Skilled nurse visit services.** (a) Skilled nurse visit services must be provided by a registered nurse or a licensed practical nurse under the supervision of a registered nurse, according to the written plan of care and accepted standards of medical and nursing practice according to chapter 148. Skilled nurse visit services must be ordered by a physician and documented in a plan of care that is reviewed and approved by the ordering physician at least once every 60 days. All skilled nurse visits must be medically necessary and provided in the recipient's home residence except as allowed under section 256B.0625, subdivision 6a.

(b) Skilled nurse visits include face-to-face and telehomecare visits with a limit of up to two visits per day per recipient. All visits must be based on assessed needs.

(c) Telehomecare skilled nurse visits are allowed when the recipient's health status can be accurately measured and assessed without a need for a face-to-face, hands-on encounter. All telehomecare skilled nurse visits must have authorization and are paid at the same allowable rates as face-to-face skilled nurse visits.

(d) The provision of telehomecare must be made via live, two-way interactive audiovisual technology and may be augmented by utilizing store-and-forward technologies. Individually identifiable patient data obtained through real-time or store-and-forward technology must be maintained as health records according

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to sections 144.291 to 144.298. If the video is used for research, training, or other purposes unrelated to the care of the patient, the identity of the patient must be concealed.

(e) Authorization for skilled nurse visits must be completed under section 256B.0652. A total of nine face-to-face skilled nurse visits per calendar year do not require authorization. All telehomecare skilled nurse visits require authorization.

Subd. 5. **Home care therapies.** (a) Home care therapies include the following: physical therapy, occupational therapy, respiratory therapy, and speech and language pathology therapy services.

(b) Home care therapies must be:

(1) provided in the recipient's residence after it has been determined the recipient is unable to access outpatient therapy;

(2) prescribed, ordered, or referred by a physician and documented in a plan of care and reviewed, according to Minnesota Rules, part 9505.0390;

(3) assessed by an appropriate therapist; and

(4) provided by a Medicare-certified home health agency enrolled as a Medicaid provider agency.

(c) Restorative and specialized maintenance therapies must be provided according to Minnesota Rules, part 9505.0390. Physical and occupational therapy assistants may be used as allowed under Minnesota Rules, part 9505.0390, subpart 1, item B.

(d) For both physical and occupational therapies, the therapist and the therapist's assistant may not both bill for services provided to a recipient on the same day.

Subd. 6. **Noncovered home health agency services.** The following are not eligible for payment under medical assistance as a home health agency service:

(1) telehomecare skilled nurses services that is communication between the home care nurse and recipient that consists solely of a telephone conversation, facsimile, electronic mail, or a consultation between two health care practitioners;

(2) the following skilled nurse visits:

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

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

(iii) services done for the sole purpose of supervision of the home health aide or personal care assistant;

(iv) services done for the sole purpose to train other home health agency workers;

(v) services done for the sole purpose of blood samples or lab draw when the recipient is able to access these services outside the home; and

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(vi) Medicare evaluation or administrative nursing visits required by Medicare;

(3) home health aide visits when the following activities are the sole purpose for the visit: companionship, socialization, household tasks, transportation, and education; and

(4) home care therapies provided in other settings such as a clinic, day program, or as an inpatient or when the recipient can access therapy outside of the recipient's residence.

History: *1986 c 444; 1990 c 568 art 3 s 51; 1991 c 292 art 7 s 12,25; 1992 c 391 s 3-6; 1992 c 464 art 2 s 1; 1992 c 513 art 7 s 50; 1Sp1993 c 1 art 5 s 51-53; 1995 c 207 art 6 s 52-55; 1996 c 451 art 5 s 17-20; 1997 c 203 art 4 s 28,29; 3Sp1997 c 3 s 9; 1998 c 407 art 4 s 29-31; 1999 c 245 art 4 s 50-58; 2000 c 474 s 8-11; 1Sp2001 c 9 art 3 s 29-41; 2002 c 375 art 2 s 17; 2002 c 379 art 1 s 113; 2003 c 15 art 1 s 33; 1Sp2003 c 14 art 3 s 26-28; 2005 c 10 art 1 s 49,50; 1Sp2005 c 4 art 7 s 15-19; 2007 c 147 art 10 s 15; 2009 c 79 art 8 s 25; 2010 c 352 art 2 s 1*

256B.0654 HOME CARE NURSING.

Subdivision 1. **Definitions.** (a) "Complex home care nursing" means home care nursing services provided to recipients who meet the criteria for regular home care nursing and require life-sustaining interventions to reduce the risk of long-term injury or death.

(b) "Home care nursing" means ongoing physician-ordered hourly nursing services performed by a registered nurse or licensed practical nurse within the scope of practice as defined by the Minnesota Nurse Practice Act under sections 148.171 to 148.285, in order to maintain or restore a person's health.

(c) "Home care nursing agency" means a medical assistance enrolled provider licensed under chapter 144A to provide home care nursing services.

(d) "Regular home care nursing" means home care nursing provided because:

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

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

(e) "Shared home care nursing" means the provision of home care nursing services by a home care nurse to two recipients at the same time and in the same setting.

Subd. 2. MS 2008 [Renumbered 256B.0652, subd 5]

Subd. 2a. **Home care nursing services.** (a) Home care nursing services must be used:

(1) in the recipient's home or outside the home when normal life activities require;

(2) when the recipient requires more individual and continuous care than can be provided during a skilled nurse visit; and

(3) when the care required is outside of the scope of services that can be provided by a home health aide or personal care assistant.

(b) Home care nursing services must be:

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(1) assessed by a registered nurse on a form approved by the commissioner;

(2) ordered by a physician and documented in a plan of care that is reviewed by the physician at least once every 60 days; and

(3) authorized by the commissioner under section 256B.0652.

Subd. 2b. **Noncovered home care nursing services.** Home care nursing services do not cover the following:

(1) nursing services by a nurse who is the family foster care provider of a person who has not reached 18 years of age unless allowed under subdivision 4;

(2) nursing services to more than two persons receiving shared home care nursing services from a home care nurse in a single setting; and

(3) nursing services provided by a registered nurse or licensed practical nurse who is the recipient's legal guardian or related to the recipient as spouse, parent, or family foster parent whether by blood, marriage, or adoption except as specified in section 256B.0652, subdivision 4.

Subd. 3. **Shared home care nursing option.** (a) Medical assistance payments for shared home care nursing services by a home care nurse shall be limited according to this subdivision. Unless otherwise provided in this subdivision, all other statutory and regulatory provisions relating to home care nursing services apply to shared home care nursing services. Nothing in this subdivision shall be construed to reduce the total number of home care nursing hours authorized for an individual recipient.

(b) Shared home care nursing is the provision of nursing services by a home care nurse to two medical assistance eligible recipients at the same time and in the same setting. This subdivision does not apply when a home care nurse is caring for multiple recipients in more than one setting.

(c) For the purposes of this subdivision, "setting" means:

(1) the home residence or foster care home of one of the individual recipients as defined in section 256B.0651;

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

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

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

(d) The home care nursing agency must offer the recipient the option of shared or one-on-one home care nursing services. The recipient may withdraw from participating in a shared service arrangement at any time.

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

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

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(2) the amount of shared home care nursing services authorized as part of the overall authorization of nursing services.

(f) The recipient or the recipient's legal representative, in conjunction with the home care nursing agency, shall approve the setting, grouping, and arrangement of shared home care 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.

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

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

(2) the setting in which the shared home care 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 home care 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.

(h) The documentation for shared home care nursing must be on a form approved by the commissioner for each individual recipient sharing home care nursing. The documentation must be part of the recipient's health service record and include:

(1) permission by the recipient or the recipient's legal representative for the maximum number of shared nursing hours per week chosen by the recipient and permission for shared home care nursing services provided in and outside the recipient's home residence;

(2) revocation by the recipient or the recipient's legal representative for the shared home care nursing permission, or services provided to others in and outside the recipient's residence; and

(3) daily documentation of the shared home care nursing services provided by each identified home care nurse, including:

(i) the names of each recipient receiving shared home care nursing services;

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

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

(i) The commissioner shall provide a rate methodology for shared home care nursing. For two persons sharing nursing care, the rate paid to a provider must not exceed 1.5 times the regular home care nursing

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rates paid for serving a single individual by a registered nurse or licensed practical nurse. These rates apply only to situations in which both recipients are present and receive shared home care nursing care on the date for which the service is billed.

Subd. 4. **Hardship criteria; home care nursing.** (a) Payment is allowed for extraordinary services that require specialized nursing skills and are provided by parents of minor children, family foster parents, spouses, and legal guardians who are providing home care nursing care under the following conditions:

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

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

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

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

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

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

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

(b) Home care nursing may be provided by a parent, spouse, family foster parent, or legal guardian who is a nurse licensed in Minnesota. Home care nursing services provided by a parent, spouse, family foster parent, or legal guardian cannot be used in lieu of nursing services covered and available under liable third-party payors, including Medicare. The home care nursing provided by a parent, spouse, family foster parent, or legal guardian must be included in the service agreement. Authorized nursing services for a single recipient or recipients with the same residence and provided by the parent, spouse, family foster parent, or legal guardian may not exceed 50 percent of the total approved nursing hours, or eight hours per day, whichever is less, up to a maximum of 40 hours per week. A parent or parents, spouse, family foster parent, or legal guardian shall not provide more than 40 hours of services in a seven-day period. For parents, family foster parents, and legal guardians, 40 hours is the total amount allowed regardless of the number of children or adults who receive services. Nothing in this subdivision precludes the parent's, spouse's, or legal guardian's obligation of assuming the nonreimbursed family responsibilities of emergency backup caregiver and primary caregiver.

(c) A parent, family foster parent, or a spouse may not be paid to provide home care nursing care if:

(1) the parent or spouse fails to pass a criminal background check according to chapter 245C;

(2) it has been determined by the home care nursing agency, the case manager, or the physician that the home care nursing provided by the parent, family foster parent, spouse, or legal guardian is unsafe; or

(3) the parent, family foster parent, spouse, or legal guardian does not follow physician orders.

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(d) For purposes of this section, "assessment" means a review and evaluation of a recipient's need for home care services conducted in person. Assessments for home care nursing must be conducted by a registered nurse.

History: *1986 c 444; 1990 c 568 art 3 s 51; 1991 c 292 art 7 s 12,25; 1992 c 391 s 3-6; 1992 c 464 art 2 s 1; 1992 c 513 art 7 s 50; 1Sp1993 c 1 art 5 s 51-53; 1995 c 207 art 6 s 52-55; 1996 c 451 art 5 s 17-20; 1997 c 203 art 4 s 28,29; 3Sp1997 c 3 s 9; 1998 c 407 art 4 s 29-31; 1999 c 245 art 4 s 50-58; 2000 c 474 s 8-11; 1Sp2001 c 9 art 3 s 29-41; 2002 c 375 art 2 s 17; 2002 c 379 art 1 s 113; 2003 c 15 art 1 s 33; 1Sp2003 c 14 art 3 s 26-28; 2005 c 10 art 1 s 49,50; 2005 c 56 s 1; 1Sp2005 c 4 art 7 s 15-19; 2009 c 79 art 8 s 26,85; 2014 c 291 art 9 s 2,5*

256B.0655 Subdivision 1. [Repealed, 2009 c 79 art 8 s 86]

Subd. 1a. [Repealed, 2009 c 79 art 8 s 86]

Subd. 1b. MS 2008 [Renumbered 256B.0659, subd 3a]

Subd. 1c. [Repealed, 2009 c 79 art 8 s 86]

Subd. 1d. [Repealed, 2009 c 79 art 8 s 86]

Subd. 1e. [Repealed, 2009 c 79 art 8 s 86]

Subd. 1f. [Repealed, 2009 c 79 art 8 s 86]

Subd. 1g. [Repealed, 2009 c 79 art 8 s 86]

Subd. 1h. [Repealed, 2009 c 79 art 8 s 86]

Subd. 1i. [Repealed, 2009 c 79 art 8 s 86]

Subd. 2. [Repealed, 2009 c 79 art 8 s 86]

Subd. 3. [Repealed, 2009 c 79 art 8 s 86]

Subd. 4. MS 2008 [Renumbered 256B.0652, subd 6]

Subd. 5. [Repealed, 2009 c 79 art 8 s 86]

Subd. 6. [Repealed, 2009 c 79 art 8 s 86]

Subd. 7. [Repealed, 2009 c 79 art 8 s 86]

Subd. 8. [Repealed, 2009 c 79 art 8 s 86]

Subd. 9. [Repealed, 2009 c 79 art 8 s 86]

Subd. 10. [Repealed, 2009 c 79 art 8 s 86]

Subd. 11. [Repealed, 2009 c 79 art 8 s 86]

Subd. 12. [Repealed, 2009 c 79 art 8 s 86]

Subd. 13. [Repealed, 2009 c 79 art 8 s 86]

256B.0656 [Repealed, 2014 c 262 art 4 s 9]

256B.0657 [Repealed, 2014 c 262 art 4 s 9]

256B.0658 HOUSING ACCESS GRANTS.

The commissioner of human services shall award through a competitive process contracts for grants to public and private agencies to support and assist individuals eligible for publicly funded home and

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community-based services, including state plan home care, to access housing. Grants may be awarded to agencies that may include, but are not limited to, the following supports: assessment to ensure suitability of housing, accompanying an individual to look at housing, filling out applications and rental agreements, meeting with landlords, helping with Section 8 or other program applications, helping to develop a budget, obtaining furniture and household goods, if necessary, and assisting with any problems that may arise with housing.

History: *2008 c 363 art 15 s 5*

256B.0659 PERSONAL CARE ASSISTANCE PROGRAM.

Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms defined in paragraphs (b) to (r) have the meanings given unless otherwise provided in text.

(b) "Activities of daily living" means grooming, dressing, bathing, transferring, mobility, positioning, eating, and toileting.

(c) "Behavior," effective January 1, 2010, means a category to determine the home care rating and is based on the criteria found in this section. "Level I behavior" means physical aggression towards self, others, or destruction of property that requires the immediate response of another person.

(d) "Complex health-related needs," effective January 1, 2010, means a category to determine the home care rating and is based on the criteria found in this section.

(e) "Critical activities of daily living," effective January 1, 2010, means transferring, mobility, eating, and toileting.

(f) "Dependency in activities of daily living" means a person requires assistance to begin and complete one or more of the activities of daily living.

(g) "Extended personal care assistance service" means personal care assistance services included in a service plan under one of the home and community-based services waivers authorized under sections 256B.0915, 256B.092, subdivision 5, and 256B.49, which exceed the amount, duration, and frequency of the state plan personal care assistance services for participants who:

(1) need assistance provided periodically during a week, but less than daily will not be able to remain in their homes without the assistance, and other replacement services are more expensive or are not available when personal care assistance services are to be reduced; or

(2) need additional personal care assistance services beyond the amount authorized by the state plan personal care assistance assessment in order to ensure that their safety, health, and welfare are provided for in their homes.

(h) "Health-related procedures and tasks" means procedures and tasks that can be delegated or assigned by a licensed health care professional under state law to be performed by a personal care assistant.

(i) "Instrumental activities of daily living" means activities to include meal planning and preparation; basic assistance with paying bills; shopping for food, clothing, and other essential items; performing household tasks integral to the personal care assistance services; communication by telephone and other media; and traveling, including to medical appointments and to participate in the community.

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(j) "Managing employee" has the same definition as Code of Federal Regulations, title 42, section 455.

(k) "Qualified professional" means a professional providing supervision of personal care assistance services and staff as defined in section 256B.0625, subdivision 19c.

(l) "Personal care assistance provider agency" means a medical assistance enrolled provider that provides or assists with providing personal care assistance services and includes a personal care assistance provider organization, personal care assistance choice agency, class A licensed nursing agency, and Medicare-certified home health agency.

(m) "Personal care assistant" or "PCA" means an individual employed by a personal care assistance agency who provides personal care assistance services.

(n) "Personal care assistance care plan" means a written description of personal care assistance services developed by the personal care assistance provider according to the service plan.

(o) "Responsible party" means an individual who is capable of providing the support necessary to assist the recipient to live in the community.

(p) "Self-administered medication" means medication taken orally, by injection, nebulizer, or insertion, or applied topically without the need for assistance.

(q) "Service plan" means a written summary of the assessment and description of the services needed by the recipient.

(r) "Wages and benefits" means wages and salaries, the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, mileage reimbursement, health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, and contributions to employee retirement accounts.

Subd. 2. **Personal care assistance services; covered services.** (a) The personal care assistance services eligible for payment include services and supports furnished to an individual, as needed, to assist in:

(1) activities of daily living;

(2) health-related procedures and tasks;

(3) observation and redirection of behaviors; and

(4) instrumental activities of daily living.

(b) Activities of daily living include the following covered services:

(1) dressing, including assistance with choosing, application, and changing of clothing and application of special appliances, wraps, or clothing;

(2) grooming, including assistance with basic hair care, oral care, shaving, applying cosmetics and deodorant, and care of eyeglasses and hearing aids. Nail care is included, except for recipients who are diabetic or have poor circulation;

(3) bathing, including assistance with basic personal hygiene and skin care;

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(4) eating, including assistance with hand washing and application of orthotics required for eating, transfers, and feeding;

(5) transfers, including assistance with transferring the recipient from one seating or reclining area to another;

(6) mobility, including assistance with ambulation, including use of a wheelchair. Mobility does not include providing transportation for a recipient;

(7) positioning, including assistance with positioning or turning a recipient for necessary care and comfort; and

(8) toileting, including assistance with helping recipient with bowel or bladder elimination and care including transfers, mobility, positioning, feminine hygiene, use of toileting equipment or supplies, cleansing the perineal area, inspection of the skin, and adjusting clothing.

(c) Health-related procedures and tasks include the following covered services:

(1) range of motion and passive exercise to maintain a recipient's strength and muscle functioning;

(2) assistance with self-administered medication as defined by this section, including reminders to take medication, bringing medication to the recipient, and assistance with opening medication under the direction of the recipient or responsible party, including medications given through a nebulizer;

(3) interventions for seizure disorders, including monitoring and observation; and

(4) other activities considered within the scope of the personal care service and meeting the definition of health-related procedures and tasks under this section.

(d) A personal care assistant may provide health-related procedures and tasks associated with the complex health-related needs of a recipient if the procedures and tasks meet the definition of health-related procedures and tasks under this section and the personal care assistant is trained by a qualified professional and demonstrates competency to safely complete the procedures and tasks. Delegation of health-related procedures and tasks and all training must be documented in the personal care assistance care plan and the recipient's and personal care assistant's files. A personal care assistant must not determine the medication dose or time for medication.

(e) Effective January 1, 2010, for a personal care assistant to provide the health-related procedures and tasks of tracheostomy suctioning and services to recipients on ventilator support there must be:

(1) delegation and training by a registered nurse, certified or licensed respiratory therapist, or a physician;

(2) utilization of clean rather than sterile procedure;

(3) specialized training about the health-related procedures and tasks and equipment, including ventilator operation and maintenance;

(4) individualized training regarding the needs of the recipient; and

(5) supervision by a qualified professional who is a registered nurse.

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(f) Effective January 1, 2010, a personal care assistant may observe and redirect the recipient for episodes where there is a need for redirection due to behaviors. Training of the personal care assistant must occur based on the needs of the recipient, the personal care assistance care plan, and any other support services provided.

(g) Instrumental activities of daily living under subdivision 1, paragraph (i).

Subd. 3. **Noncovered personal care assistance services.** (a) Personal care assistance services are not eligible for medical assistance payment under this section when provided:

(1) by the recipient's spouse, parent of a recipient under the age of 18, paid legal guardian, licensed foster provider, except as allowed under section 256B.0652, subdivision 10, or responsible party;

(2) in order to meet staffing or license requirements in a residential or child care setting;

(3) solely as a child care or babysitting service; or

(4) without authorization by the commissioner or the commissioner's designee.

(b) The following personal care services are not eligible for medical assistance payment under this section when provided in residential settings:

(1) when the provider of home care services who is not related by blood, marriage, or adoption owns or otherwise controls the living arrangement, including licensed or unlicensed services; or

(2) when personal care assistance services are the responsibility of a residential or program license holder under the terms of a service agreement and administrative rules.

(c) Other specific tasks not covered under paragraph (a) or (b) that are not eligible for medical assistance reimbursement for personal care assistance services under this section include:

(1) sterile procedures;

(2) injections of fluids and medications into veins, muscles, or skin;

(3) home maintenance or chore services;

(4) homemaker services not an integral part of assessed personal care assistance services needed by a recipient;

(5) application of restraints or implementation of procedures under section 245.825;

(6) instrumental activities of daily living for children under the age of 18, except when immediate attention is needed for health or hygiene reasons integral to the personal care services and the need is listed in the service plan by the assessor; and

(7) assessments for personal care assistance services by personal care assistance provider agencies or by independently enrolled registered nurses.

Subd. 3a. **Assessment; defined.** (a) "Assessment" means a review and evaluation of a recipient's need for personal care assistance services conducted in person. Assessments for personal care assistance services shall be conducted by the county public health nurse or a certified public health nurse under contract with the county except when a long-term care consultation assessment is being conducted for the purposes of

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determining a person's eligibility for home and community-based waiver services including personal care assistance services according to section 256B.0911. An in-person assessment must include: documentation of health status, determination of need, evaluation of service effectiveness, identification of appropriate services, service plan development or modification, coordination of services, referrals and follow-up to appropriate payers and community resources, completion of required reports, recommendation of service authorization, and consumer education. Once the need for personal care assistance services is determined under this section, the county public health nurse or certified public health nurse under contract with the county is responsible for communicating this recommendation to the commissioner and the recipient. An in-person 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 assistance 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 assistance service. A service update may be completed by telephone, used when there is no need for an increase in personal care assistance services, and used for two consecutive assessments if followed by a face-to-face assessment. A service update must be completed on a form approved by the commissioner. A service update or review for temporary increase includes a review of initial baseline data, evaluation of service effectiveness, redetermination of service need, modification of service plan and appropriate referrals, update of initial forms, obtaining service authorization, and on going consumer education. Assessments or reassessments 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) This subdivision expires when notification is given by the commissioner as described in section 256B.0911, subdivision 3a.

Subd. 4. **Assessment for personal care assistance services; limitations.** (a) An assessment as defined in subdivision 3a must be completed for personal care assistance services.

(b) The following limitations apply to the assessment:

(1) a person must be assessed as dependent in an activity of daily living based on the person's daily need or need on the days during the week the activity is completed for:

(i) cuing and constant supervision to complete the task; or

(ii) hands-on assistance to complete the task; and

(2) 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. Assistance needed is the assistance appropriate for a typical child of the same age.

(c) Assessment for complex health-related needs must meet the criteria in this paragraph. A recipient qualifies as having complex health-related needs if the recipient has one or more of the interventions that are ordered by a physician, specified in a personal care assistance care plan or community support plan developed under section 256B.0911, and found in the following:

(1) tube feedings requiring:

(i) a gastrojejunostomy tube; or

(ii) continuous tube feeding lasting longer than 12 hours per day;

(2) wounds described as:

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(i) stage III or stage IV;

(ii) multiple wounds;

(iii) requiring sterile or clean dressing changes or a wound vac; or

(iv) open lesions such as burns, fistulas, tube sites, or ostomy sites that require specialized care;

(3) parenteral therapy described as:

(i) IV therapy more than two times per week lasting longer than four hours for each treatment; or

(ii) total parenteral nutrition (TPN) daily;

(4) respiratory interventions, including:

(i) oxygen required more than eight hours per day;

(ii) respiratory vest more than one time per day;

(iii) bronchial drainage treatments more than two times per day;

(iv) sterile or clean suctioning more than six times per day;

(v) dependence on another to apply respiratory ventilation augmentation devices such as BiPAP and CPAP; and

(vi) ventilator dependence under section 256B.0652;

(5) insertion and maintenance of catheter, including:

(i) sterile catheter changes more than one time per month;

(ii) clean intermittent catheterization, and including self-catheterization more than six times per day; or

(iii) bladder irrigations;

(6) bowel program more than two times per week requiring more than 30 minutes to perform each time;

(7) neurological intervention, including:

(i) seizures more than two times per week and requiring significant physical assistance to maintain safety; or

(ii) swallowing disorders diagnosed by a physician and requiring specialized assistance from another on a daily basis; and

(8) other congenital or acquired diseases creating a need for significantly increased direct hands-on assistance and interventions in six to eight activities of daily living.

(d) An assessment of behaviors must meet the criteria in this paragraph. A recipient qualifies as having a need for assistance due to behaviors if the recipient's behavior requires assistance at least four times per week and shows one or more of the following behaviors:

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(1) physical aggression towards self or others, or destruction of property that requires the immediate response of another person;

(2) increased vulnerability due to cognitive deficits or socially inappropriate behavior; or

(3) increased need for assistance for recipients who are verbally aggressive or resistive to care so that the time needed to perform activities of daily living is increased.

Subd. 5. **Service, support planning, and referral.** (a) The assessor, with the recipient or responsible party, shall review the assessment information and determine referrals for other payers, services, and community supports as appropriate.

(b) The recipient must be referred for evaluation, services, or supports that are appropriate to help meet the recipient's needs including, but not limited to, the following circumstances:

(1) when there is another payer who is responsible to provide the service to meet the recipient's needs;

(2) when the recipient qualifies for assistance due to mental illness or behaviors under this section, a referral for a mental health diagnostic and functional assessment must be completed, or referral must be made for other specific mental health services or other community services;

(3) when the recipient is eligible for medical assistance and meets medical assistance eligibility for a home health aide or skilled nurse visit;

(4) when the recipient would benefit from an evaluation for another service; and

(5) when there is a more appropriate service to meet the assessed needs.

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

(1) $210.50 for a face-to-face assessment visit;

(2) $105.25 for each service update; and

(3) $105.25 for each request for a temporary service increase.

(d) The rates specified in paragraph (c) must be adjusted to reflect provider rate increases for personal care assistance 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 assistance services also apply to adjustments under this paragraph.

(e) Effective July 1, 2008, the payment rate for an assessment under this section and section 256B.0651 shall be reduced by 25 percent when the assessment is not completed on time and the service agreement documentation is not submitted in time to continue services. The commissioner shall reduce the amount of the claim for those assessments that are not submitted on time.

Subd. 6. **Service plan.** The service plan must be completed by the assessor with the recipient and responsible party on a form determined by the commissioner and include a summary of the assessment with a description of the need, authorized amount, and expected outcomes and goals of personal care assistance services. The recipient and the provider chosen by the recipient or responsible party must be given a copy

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of the completed service plan within ten working days of the assessment. The recipient or responsible party must be given information by the assessor about the options in the personal care assistance program to allow for review and decision making.

Subd. 7. **Personal care assistance care plan.** (a) Each recipient must have a current personal care assistance care plan based on the service plan in subdivision 6 that is developed by the qualified professional with the recipient and responsible party. A copy of the most current personal care assistance care plan is required to be in the recipient's home and in the recipient's file at the provider agency.

(b) The personal care assistance care plan must have the following components:

(1) start and end date of the care plan;

(2) recipient demographic information, including name and telephone number;

(3) emergency numbers, procedures, and a description of measures to address identified safety and vulnerability issues, including a backup staffing plan;

(4) name of responsible party and instructions for contact;

(5) description of the recipient's individualized needs for assistance with activities of daily living, instrumental activities of daily living, health-related tasks, and behaviors; and

(6) dated signatures of recipient or responsible party and qualified professional.

(c) The personal care assistance care plan must have instructions and comments about the recipient's needs for assistance and any special instructions or procedures required, including whether or not the recipient has requested a personal care assistant of the same gender. The month-to-month plan for the use of personal care assistance services is part of the personal care assistance care plan. The personal care assistance care plan must be completed within the first week after start of services with a personal care provider agency and must be updated as needed when there is a change in need for personal care assistance services. A new personal care assistance care plan is required annually at the time of the reassessment.

Subd. 7a. **Special instructions; gender.** If a recipient requests a personal care assistant of the same gender as the recipient, the personal care assistance agency must make a reasonable effort to fulfill the request.

Subd. 8. **Communication with recipient's physician.** The personal care assistance program requires communication with the recipient's physician about a recipient's assessed needs for personal care assistance services. The commissioner shall work with the state medical director to develop options for communication with the recipient's physician.

Subd. 9. **Responsible party; generally.** (a) "Responsible party" means an individual who is capable of providing the support necessary to assist the recipient to live in the community.

(b) A responsible party must be 18 years of age, actively participate in planning and directing of personal care assistance services, and attend all assessments for the recipient.

(c) A responsible party must not be the:

(1) personal care assistant;

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(2) qualified professional;

(3) home care provider agency owner or manager;

(4) home care provider agency staff unless staff who are not listed in clauses (1) to (3) are related to the recipient by blood, marriage, or adoption; or

(5) county staff acting as part of employment.

(d) A licensed family foster parent who lives with the recipient may be the responsible party as long as the family foster parent meets the other responsible party requirements.

(e) A responsible party is required when:

(1) the person is a minor according to section 524.5-102, subdivision 10;

(2) the person is an incapacitated adult according to section 524.5-102, subdivision 6, resulting in a court-appointed guardian; or

(3) the assessment according to subdivision 3a determines that the recipient is in need of a responsible party to direct the recipient's care.

(f) There may be two persons designated as the responsible party for reasons such as divided households and court-ordered custodies. Each person named as responsible party must meet the program criteria and responsibilities.

(g) The recipient or the recipient's legal representative shall appoint a responsible party if necessary to direct and supervise the care provided to the recipient. The responsible party must be identified at the time of assessment and listed on the recipient's service agreement and personal care assistance care plan.

Subd. 10. **Responsible party; duties; delegation.** (a) A responsible party shall enter into a written agreement with a personal care assistance provider agency, on a form determined by the commissioner, to perform the following duties:

(1) be available while care is provided in a method agreed upon by the individual or the individual's legal representative and documented in the recipient's personal care assistance care plan;

(2) monitor personal care assistance services to ensure the recipient's personal care assistance care plan is being followed; and

(3) review and sign personal care assistance time sheets after services are provided to provide verification of the personal care assistance services.

Failure to provide the support required by the recipient must result in a referral to the county common entry point.

(b) Responsible parties who are parents of minors or guardians of minors or incapacitated persons may delegate the responsibility to another adult who is not the personal care assistant 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 the responsible party. The responsible party must ensure that the delegate performs the functions of the responsible party, is identified at the time of the assessment, and is listed on the personal

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care assistance care plan. The responsible party must communicate to the personal care assistance provider agency about the need for a delegated responsible party, including the name of the delegated responsible party and contact numbers.

Subd. 11. **Personal care assistant; requirements.** (a) A personal care assistant must meet the following requirements:

(1) be at least 18 years of age with the exception of persons who are 16 or 17 years of age with these additional requirements:

(i) supervision by a qualified professional every 60 days; and

(ii) employment by only one personal care assistance provider agency responsible for compliance with current labor laws;

(2) be employed by a personal care assistance provider agency;

(3) enroll with the department as a personal care assistant after clearing a background study. Except as provided in subdivision 11a, before a personal care assistant provides services, the personal care assistance provider agency must initiate a background study on the personal care assistant under chapter 245C, and the personal care assistance provider agency must have received a notice from the commissioner that the personal care assistant is:

(i) not disqualified under section 245C.14; or

(ii) is disqualified, but the personal care assistant has received a set aside of the disqualification under section 245C.22;

(4) be able to effectively communicate with the recipient and personal care assistance provider agency;

(5) be able to provide covered personal care assistance services according to the recipient's personal care assistance care plan, respond appropriately to recipient needs, and report changes in the recipient's condition to the supervising qualified professional or physician;

(6) not be a consumer of personal care assistance services;

(7) maintain daily written records including, but not limited to, time sheets under subdivision 12;

(8) effective January 1, 2010, complete standardized training as determined by the commissioner before completing enrollment. The training must be available in languages other than English and to those who need accommodations due to disabilities. Personal care assistant training must include successful completion of the following training components: basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic roles and responsibilities of personal care assistants including information about assistance with lifting and transfers for recipients, emergency preparedness, orientation to positive behavioral practices, fraud issues, and completion of time sheets. Upon completion of the training components, the personal care assistant must demonstrate the competency to provide assistance to recipients;

(9) complete training and orientation on the needs of the recipient; and

(10) be limited to providing and being paid for up to 275 hours per month of personal care assistance services regardless of the number of recipients being served or the number of personal care assistance

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provider agencies enrolled with. The number of hours worked per day shall not be disallowed by the department unless in violation of the law.

(b) A legal guardian may be a personal care assistant if the guardian is not being paid for the guardian services and meets the criteria for personal care assistants in paragraph (a).

(c) Persons who do not qualify as a personal care assistant include parents, stepparents, and legal guardians of minors; spouses; paid legal guardians of adults; family foster care providers, except as otherwise allowed in section 256B.0625, subdivision 19a; and staff of a residential setting.

Subd. 11a. **Exception to personal care assistant; requirements.** The personal care assistant for a recipient may be allowed to enroll with a different personal care assistant provider agency upon initiation of a new background study according to chapter 245C, if all of the following are met:

(1) the commissioner determines that a change in enrollment or affiliation of the personal care assistant is needed in order to ensure continuity of services and protect the health and safety of the recipient;

(2) the chosen agency has been continuously enrolled as a personal care assistance provider agency for at least two years;

(3) the recipient chooses to transfer to the personal care assistance provider agency;

(4) the personal care assistant has been continuously enrolled with the former personal care assistance provider agency since the last background study was completed; and

(5) the personal care assistant continues to meet requirements of subdivision 11, excluding paragraph (a), clause (3).

Subd. 12. **Documentation of personal care assistance services provided.** (a) Personal care assistance services for a recipient must be documented daily by each personal care assistant, on a time sheet form approved by the commissioner. All documentation may be Web-based, electronic, or paper documentation. The completed form must be submitted on a monthly basis to the provider and kept in the recipient's health record.

(b) The activity documentation must correspond to the personal care assistance care plan and be reviewed by the qualified professional.

(c) The personal care assistant time sheet must be on a form approved by the commissioner documenting time the personal care assistant provides services in the home. The following criteria must be included in the time sheet:

(1) full name of personal care assistant and individual provider number;

(2) provider name and telephone numbers;

(3) full name of recipient;

(4) consecutive dates, including month, day, and year, and arrival and departure times with a.m. or p.m. notations;

(5) signatures of recipient or the responsible party;

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(6) personal signature of the personal care assistant;

(7) any shared care provided, if applicable;

(8) a statement that it is a federal crime to provide false information on personal care service billings for medical assistance payments; and

(9) dates and location of recipient stays in a hospital, care facility, or incarceration.

Subd. 13. **Qualified professional; qualifications.** (a) The qualified professional must work for a personal care assistance provider agency and meet the definition under section 256B.0625, subdivision 19c. Before a qualified professional provides services, the personal care assistance provider agency must initiate a background study on the qualified professional under chapter 245C, and the personal care assistance provider agency must have received a notice from the commissioner that the qualified professional:

(1) is not disqualified under section 245C.14; or

(2) is disqualified, but the qualified professional has received a set aside of the disqualification under section 245C.22.

(b) The qualified professional shall perform the duties of training, supervision, and evaluation of the personal care assistance staff and evaluation of the effectiveness of personal care assistance services. The qualified professional shall:

(1) develop and monitor with the recipient a personal care assistance care plan based on the service plan and individualized needs of the recipient;

(2) develop and monitor with the recipient a monthly plan for the use of personal care assistance services;

(3) review documentation of personal care assistance services provided;

(4) provide training and ensure competency for the personal care assistant in the individual needs of the recipient; and

(5) document all training, communication, evaluations, and needed actions to improve performance of the personal care assistants.

(c) Effective July 1, 2011, the qualified professional shall complete the provider training with basic information about the personal care assistance program approved by the commissioner. Newly hired qualified professionals must complete the training within six months of the date hired by a personal care assistance provider agency. Qualified professionals who have completed the required training as a worker from a personal care assistance provider agency do not need to repeat the required training if they are hired by another agency, if they have completed the training within the last three years. The required training must be available with meaningful access according to title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Health and Human Services Department. The required training must be available online or by electronic remote connection. The required training must provide for competency testing to demonstrate an understanding of the content without attending in-person training. A qualified professional is allowed to be employed and is not subject to the training requirement until the training is offered online or through remote electronic connection. A qualified professional employed by a personal care assistance provider agency certified for participation in Medicare

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as a home health agency is exempt from the training required in this subdivision. When available, the qualified professional working for a Medicare-certified home health agency must successfully complete the competency test. The commissioner shall ensure there is a mechanism in place to verify the identity of persons completing the competency testing electronically.

Subd. 14. **Qualified professional; duties.** (a) Effective January 1, 2010, all personal care assistants must be supervised by a qualified professional.

(b) Through direct training, observation, return demonstrations, and consultation with the staff and the recipient, the qualified professional must ensure and document that the personal care assistant is:

(1) capable of providing the required personal care assistance services;

(2) knowledgeable about the plan of personal care assistance services before services are performed; and

(3) able to identify conditions that should be immediately brought to the attention of the qualified professional.

(c) The qualified professional shall evaluate the personal care assistant within the first 14 days of starting to provide regularly scheduled services for a recipient, or sooner as determined by the qualified professional, except for the personal care assistance choice option under subdivision 19, paragraph (a), clause (4). For the initial evaluation, the qualified professional shall evaluate the personal care assistance services for a recipient through direct observation of a personal care assistant's work. The qualified professional may conduct additional training and evaluation visits, based upon the needs of the recipient and the personal care assistant's ability to meet those needs. Subsequent visits to evaluate the personal care assistance services provided to a recipient do not require direct observation of each personal care assistant's work and shall occur:

(1) at least every 90 days thereafter for the first year of a recipient's services;

(2) every 120 days after the first year of a recipient's service or whenever needed for response to a recipient's request for increased supervision of the personal care assistance staff; and

(3) after the first 180 days of a recipient's service, supervisory visits may alternate between unscheduled phone or Internet technology and in-person visits, unless the in-person visits are needed according to the care plan.

(d) Communication with the recipient is a part of the evaluation process of the personal care assistance staff.

(e) At each supervisory visit, the qualified professional shall evaluate personal care assistance services including the following information:

(1) satisfaction level of the recipient with personal care assistance services;

(2) review of the month-to-month plan for use of personal care assistance services;

(3) review of documentation of personal care assistance services provided;

(4) whether the personal care assistance services are meeting the goals of the service as stated in the personal care assistance care plan and service plan;

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(5) a written record of the results of the evaluation and actions taken to correct any deficiencies in the work of a personal care assistant; and

(6) revision of the personal care assistance care plan as necessary in consultation with the recipient or responsible party, to meet the needs of the recipient.

(f) The qualified professional shall complete the required documentation in the agency recipient and employee files and the recipient's home, including the following documentation:

(1) the personal care assistance care plan based on the service plan and individualized needs of the recipient;

(2) a month-to-month plan for use of personal care assistance services;

(3) changes in need of the recipient requiring a change to the level of service and the personal care assistance care plan;

(4) evaluation results of supervision visits and identified issues with personal care assistance staff with actions taken;

(5) all communication with the recipient and personal care assistance staff; and

(6) hands-on training or individualized training for the care of the recipient.

(g) The documentation in paragraph (f) must be done on agency templates.

(h) The services that are not eligible for payment as qualified professional services include:

(1) direct professional nursing tasks that could be assessed and authorized as skilled nursing tasks;

(2) agency administrative activities;

(3) training other than the individualized training required to provide care for a recipient; and

(4) any other activity that is not described in this section.

Subd. 15. **Flexible use.** (a) "Flexible use" means the scheduled use of authorized hours of personal care assistance services, which vary within a service authorization period covering no more than six months, in order to more effectively meet the needs and schedule of the recipient. Each 12-month service agreement is divided into two six-month authorization date spans. No more than 75 percent of the total authorized units for a 12-month service agreement may be used in a six-month date span.

(b) Authorization of flexible use occurs during the authorization process under section 256B.0652. The flexible use of authorized hours does not increase the total amount of authorized hours available to a recipient. The commissioner shall not authorize additional personal care assistance services to supplement a service authorization that is exhausted before the end date under a flexible service use plan, unless the assessor determines a change in condition and a need for increased services is established. Authorized hours not used within the six-month period must not be carried over to another time period.

(c) A recipient who has terminated personal care assistance services before the end of the 12-month authorization period must not receive additional hours upon reapplying during the same 12-month autho-

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rization period, except if a change in condition is documented. Services must be prorated for the remainder of the 12-month authorization period based on the first six-month assessment.

(d) The recipient, responsible party, and qualified professional must develop a written month-to-month plan of the projected use of personal care assistance services that is part of the personal care assistance care plan and ensures:

(1) that the health and safety needs of the recipient are met throughout both date spans of the authorization period; and

(2) that the total authorized amount of personal care assistance services for each date span must not be used before the end of each date span in the authorization period.

(e) The personal care assistance provider agency shall monitor the use of personal care assistance services to ensure health and safety needs of the recipient are met throughout both date spans of the authorization period. The commissioner or the commissioner's designee shall provide written notice to the provider and the recipient or responsible party when a recipient is at risk of exceeding the personal care assistance services prior to the end of the six-month period.

(f) Misuse and abuse of the flexible use of personal care assistance services resulting in the overuse of units in a manner where the recipient will not have enough units to meet their needs for assistance and ensure health and safety for the entire six-month date span may lead to an action by the commissioner. The commissioner may take action including, but not limited to: (1) restricting recipients to service authorizations of no more than one month in duration; (2) requiring the recipient to have a responsible party; and (3) requiring a qualified professional to monitor and report services on a monthly basis.

Subd. 16. **Shared services.** (a) Medical assistance payments for shared personal care assistance services are limited according to this subdivision.

(b) Shared service is the provision of personal care assistance services by a personal care assistant to two or three recipients, eligible for medical assistance, who voluntarily enter into an agreement to receive services at the same time and in the same setting.

(c) For the purposes of this subdivision, "setting" means:

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

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

(d) Shared personal care assistance services follow the same criteria for covered services as subdivision 2.

(e) Noncovered shared personal care assistance services include the following:

(1) services for more than three recipients by one personal care assistant at one time;

(2) staff requirements for child care programs under chapter 245C;

(3) caring for multiple recipients in more than one setting;

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(4) additional units of personal care assistance based on the selection of the option; and

(5) use of more than one personal care assistance provider agency for the shared care services.

(f) The option of shared personal care assistance is elected by the recipient or the responsible party with the assistance of the assessor. The option must be determined appropriate based on the ages of the recipients, compatibility, and coordination of their assessed care needs. The recipient or the responsible party, in conjunction with the qualified professional, shall arrange the setting and grouping of shared services based on the individual needs and preferences of the recipients. The personal care assistance provider agency shall offer the recipient or the responsible party the option of shared or one-on-one personal care assistance services or a combination of both. The recipient or the responsible party may withdraw from participating in a shared services arrangement at any time.

(g) Authorization for the shared service option must be determined by the commissioner based on the criteria that the shared service is appropriate to meet all of the recipients' needs and their health and safety is maintained. The authorization of shared services is part of the overall authorization of personal care assistance services. Nothing in this subdivision must be construed to reduce the total number of hours authorized for an individual recipient.

(h) A personal care assistant providing shared personal care assistance services must:

(1) receive training specific for each recipient served; and

(2) follow all required documentation requirements for time and services provided.

(i) A qualified professional shall:

(1) evaluate the ability of the personal care assistant to provide services for all of the recipients in a shared setting;

(2) visit the shared setting as services are being provided at least once every six months or whenever needed for response to a recipient's request for increased supervision of the personal care assistance staff;

(3) provide ongoing monitoring and evaluation of the effectiveness and appropriateness of the shared services;

(4) develop a contingency plan with each of the recipients which accounts for absence of the recipient in a shared services setting due to illness or other circumstances;

(5) obtain permission from each of the recipients who are sharing a personal care assistant for number of shared hours for services provided inside and outside the home residence; and

(6) document the training completed by the personal care assistants specific to the shared setting and recipients sharing services.

Subd. 17. **Shared services; rates.** The commissioner shall provide a rate system for shared personal care assistance services. For two persons sharing services, the rate paid to a provider must not exceed one and one-half times the rate paid for serving a single individual, and for three persons sharing services, the rate paid to a provider must not exceed twice the rate paid for serving a single individual. These rates apply only when all of the criteria for the shared care personal care assistance service have been met.

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Subd. 18. **Personal care assistance choice option; generally.** (a) The commissioner may allow a recipient of personal care assistance services to use a fiscal intermediary to assist the recipient in paying and accounting for medically necessary covered personal care assistance services. Unless otherwise provided in this section, all other statutory and regulatory provisions relating to personal care assistance services apply to a recipient using the personal care assistance choice option.

(b) Personal care assistance choice is an option of the personal care assistance program that allows the recipient who receives personal care assistance services to be responsible for the hiring, training, scheduling, and firing of personal care assistants according to the terms of the written agreement with the personal care assistance choice agency required under subdivision 20, paragraph (a). This program offers greater control and choice for the recipient in who provides the personal care assistance service and when the service is scheduled. The recipient or the recipient's responsible party must choose a personal care assistance choice provider agency as a fiscal intermediary. This personal care assistance choice provider agency manages payroll, invoices the state, is responsible for all payroll-related taxes and insurance, and is responsible for providing the consumer training and support in managing the recipient's personal care assistance services.

Subd. 19. **Personal care assistance choice option; qualifications; duties.** (a) Under personal care assistance choice, the recipient or responsible party shall:

(1) recruit, hire, schedule, and terminate personal care assistants according to the terms of the written agreement required under subdivision 20, paragraph (a);

(2) develop a personal care assistance care plan based on the assessed needs and addressing the health and safety of the recipient with the assistance of a qualified professional as needed;

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

(4) effective January 1, 2010, supervise and evaluate the personal care assistant with the qualified professional, who is required to visit the recipient at least every 180 days;

(5) monitor and verify in writing and report to the personal care assistance choice agency the number of hours worked by the personal care assistant and the qualified professional;

(6) engage in an annual face-to-face reassessment to determine continuing eligibility and service authorization; and

(7) use the same personal care assistance choice provider agency if shared personal assistance care is being used.

(b) The personal care assistance choice provider agency shall:

(1) meet all personal care assistance provider agency standards;

(2) enter into a written agreement with the recipient, responsible party, and personal care assistants;

(3) not be related as a parent, child, sibling, or spouse to the recipient or the personal care assistant; and

(4) ensure arm's-length transactions without undue influence or coercion with the recipient and personal care assistant.

(c) The duties of the personal care assistance choice provider agency are to:

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(1) be the employer of the personal care assistant and the qualified professional for employment law and related regulations including, but not limited to, purchasing and maintaining workers' compensation, unemployment insurance, surety and fidelity bonds, and liability insurance, and submit any or all necessary documentation including, but not limited to, workers' compensation and unemployment insurance;

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

(3) request and complete background studies that comply with the requirements for personal care assistants and qualified professionals;

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

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

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

(7) make the arrangements and pay taxes and other benefits, if any, and comply with any legal requirements for a Minnesota employer;

(8) enroll in the medical assistance program as a personal care assistance choice agency; and

(9) enter into a written agreement as specified in subdivision 20 before services are provided.

Subd. 20. **Personal care assistance choice option; administration.** (a) Before services commence under the personal care assistance choice option, and annually thereafter, the personal care assistance choice provider agency and the recipient or responsible party shall enter into a written agreement. The annual agreement must be provided to the recipient or responsible party, each personal care assistant, and the qualified professional when completed, and include at a minimum:

(1) duties of the recipient, qualified professional, personal care assistant, and personal care assistance choice provider agency;

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

(3) administrative fee of the personal care assistance choice provider agency and services paid for with that fee, including background study fees;

(4) grievance procedures to respond to complaints;

(5) procedures for hiring and terminating the personal care assistant; and

(6) documentation requirements including, but not limited to, time sheets, activity records, and the personal care assistance care plan.

(b) Effective January 1, 2010, except for the administrative fee of the personal care assistance choice provider agency as reported on the written agreement, the remainder of the rates paid to the personal care assistance choice provider agency must be used to pay for the salary and benefits for the personal care assistant or the qualified professional. The provider agency must use a minimum of 72.5 percent of the revenue generated by the medical assistance rate for personal care assistance services for employee personal care assistant wages and benefits. The revenue generated by the qualified professional and the reasonable costs associated with the qualified professional shall not be used in making this calculation.

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(c) The commissioner shall deny, revoke, or suspend the authorization to use the personal care assistance choice option if:

(1) it has been determined by the qualified professional or 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 this subdivision;

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

(4) the department terminates the personal care assistance choice option.

(d) The recipient or responsible party may appeal the commissioner's decision in paragraph (c) according to section 256.045. The denial, revocation, or suspension to use the personal care assistance choice option must not affect the recipient's authorized level of personal care assistance services.

Subd. 21. **Requirements for provider enrollment of personal care assistance provider agencies.** (a) All personal care assistance provider agencies must provide, at the time of enrollment, reenrollment, and revalidation as a personal care assistance provider agency in a format determined by the commissioner, information and documentation that includes, but is not limited to, the following:

(1) the personal care assistance provider agency's current contact information including address, telephone number, and e-mail address;

(2) proof of surety bond coverage. Upon new enrollment, or if the provider's Medicaid revenue in the previous calendar year is up to and including $300,000, the provider agency must purchase a surety bond of $50,000. If the Medicaid revenue in the previous year is over $300,000, the provider agency must purchase a surety bond of $100,000. The surety bond must be in a form approved by the commissioner, must be renewed annually, and must allow for recovery of costs and fees in pursuing a claim on the bond;

(3) proof of fidelity bond coverage in the amount of $20,000;

(4) proof of workers' compensation insurance coverage;

(5) proof of liability insurance;

(6) a description of the personal care assistance provider agency's organization identifying the names of all owners, managing employees, staff, board of directors, and the affiliations of the directors, owners, or staff to other service providers;

(7) a copy of the personal care assistance provider agency's written policies and procedures including: hiring of employees; training requirements; service delivery; and employee and consumer safety including process for notification and resolution of consumer grievances, identification and prevention of communicable diseases, and employee misconduct;

(8) copies of all other forms the personal care assistance provider agency uses in the course of daily business including, but not limited to:

(i) a copy of the personal care assistance provider agency's time sheet if the time sheet varies from the standard time sheet for personal care assistance services approved by the commissioner, and a letter requesting approval of the personal care assistance provider agency's nonstandard time sheet;

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(ii) the personal care assistance provider agency's template for the personal care assistance care plan; and

(iii) the personal care assistance provider agency's template for the written agreement in subdivision 20 for recipients using the personal care assistance choice option, if applicable;

(9) a list of all training and classes that the personal care assistance provider agency requires of its staff providing personal care assistance services;

(10) documentation that the personal care assistance provider agency and staff have successfully completed all the training required by this section;

(11) documentation of the agency's marketing practices;

(12) disclosure of ownership, leasing, or management of all residential properties that is used or could be used for providing home care services;

(13) documentation that the agency will use the following percentages of revenue generated from the medical assistance rate paid for personal care assistance services for employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal care assistance choice option and 72.5 percent of revenue from other personal care assistance providers. The revenue generated by the qualified professional and the reasonable costs associated with the qualified professional shall not be used in making this calculation; and

(14) effective May 15, 2010, documentation that the agency does not burden recipients' free exercise of their right to choose service providers by requiring personal care assistants to sign an agreement not to work with any particular personal care assistance recipient or for another personal care assistance provider agency after leaving the agency and that the agency is not taking action on any such agreements or requirements regardless of the date signed.

(b) Personal care assistance provider agencies shall provide the information specified in paragraph (a) to the commissioner at the time the personal care assistance provider agency enrolls as a vendor or upon request from the commissioner. The commissioner shall collect the information specified in paragraph (a) from all personal care assistance providers beginning July 1, 2009.

(c) All personal care assistance provider agencies shall require all employees in management and supervisory positions and owners of the agency who are active in the day-to-day management and operations of the agency to complete mandatory training as determined by the commissioner before enrollment of the agency as a provider. Employees in management and supervisory positions and owners who are active in the day-to-day operations of an agency who have completed the required training as an employee with a personal care assistance provider agency do not need to repeat the required training if they are hired by another agency, if they have completed the training within the past three years. By September 1, 2010, the required training must be available with meaningful access according to title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Health and Human Services Department. The required training must be available online or by electronic remote connection. The required training must provide for competency testing. Personal care assistance provider agency billing staff shall complete training about personal care assistance program financial management. This training is effective July 1, 2009. Any personal care assistance provider agency enrolled before that date shall, if it has not already, complete the provider training within 18 months of July 1, 2009. Any new owners or employees in management and supervisory positions involved in the day-to-day operations are required to complete mandatory training as a requisite of working for the agency. Personal care assistance provider agencies

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certified for participation in Medicare as home health agencies are exempt from the training required in this subdivision. When available, Medicare-certified home health agency owners, supervisors, or managers must successfully complete the competency test.

Subd. 22. **Annual review for personal care providers.** (a) All personal care assistance provider agencies shall resubmit, on an annual basis, the information specified in subdivision 21, in a format determined by the commissioner, and provide a copy of the personal care assistance provider agency's most current version of its grievance policies and procedures along with a written record of grievances and resolutions of the grievances that the personal care assistance provider agency has received in the previous year and any other information requested by the commissioner.

(b) The commissioner shall send annual review notification to personal care assistance provider agencies 30 days prior to renewal. The notification must:

(1) list the materials and information the personal care assistance provider agency is required to submit;

(2) provide instructions on submitting information to the commissioner; and

(3) provide a due date by which the commissioner must receive the requested information.

Personal care assistance provider agencies shall submit required documentation for annual review within 30 days of notification from the commissioner. If no documentation is submitted, the personal care assistance provider agency enrollment number must be terminated or suspended.

(c) Personal care assistance provider agencies also currently licensed under Minnesota Rules, part 4668.0012, as a class A provider or currently certified for participation in Medicare as a home health agency are deemed in compliance with the personal care assistance requirements for enrollment, annual review process, and documentation.

Subd. 23. **Enrollment requirements following termination.** (a) A terminated personal care assistance provider agency, including all named individuals on the current enrollment disclosure form and known or discovered affiliates of the personal care assistance provider agency, is not eligible to enroll as a personal care assistance provider agency for two years following the termination.

(b) After the two-year period in paragraph (a), if the provider seeks to reenroll as a personal care assistance provider agency, the personal care assistance provider agency must be placed on a one-year probation period, beginning after completion of the following:

(1) the department's provider trainings under this section; and

(2) initial enrollment requirements under subdivision 21.

(c) During the probationary period the commissioner shall complete site visits and request submission of documentation to review compliance with program policy.

Subd. 24. **Personal care assistance provider agency; general duties.** A personal care assistance provider agency shall:

(1) enroll as a Medicaid provider meeting all provider standards, including completion of the required provider training;

(2) comply with general medical assistance coverage requirements;

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(3) demonstrate compliance with law and policies of the personal care assistance program to be determined by the commissioner;

(4) comply with background study requirements;

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

(6) not engage in any agency-initiated direct contact or marketing in person, by phone, or other electronic means to potential recipients, guardians, or family members;

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

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

(9) effective January 1, 2010, document that the agency uses a minimum of 72.5 percent of the revenue generated by the medical assistance rate for personal care assistance services for employee personal care assistant wages and benefits. The revenue generated by the qualified professional and the reasonable costs associated with the qualified professional shall not be used in making this calculation;

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

(11) enter into a written agreement under subdivision 20 before services are provided;

(12) report suspected neglect and abuse to the common entry point according to section 256B.0651;

(13) provide the recipient with a copy of the home care bill of rights at start of service; and

(14) request reassessments at least 60 days prior to the end of the current authorization for personal care assistance services, on forms provided by the commissioner.

Subd. 25. **Personal care assistance provider agency; background studies.** Personal care assistance provider agencies enrolled to provide personal care assistance services under the medical assistance program shall comply with the following:

(1) owners who have a five percent interest or more and all managing employees are subject to a background study as provided in chapter 245C. This applies to currently enrolled personal care assistance provider agencies and those agencies seeking enrollment as a personal care assistance provider agency. "Managing employee" has the same meaning as Code of Federal Regulations, title 42, section 455. An organization is barred from enrollment if:

(i) the organization has not initiated background studies on owners and managing employees; or

(ii) the organization has initiated background studies on owners and managing employees, but the commissioner has sent the organization a notice that an owner or managing employee of the organization has been disqualified under section 245C.14, and the owner or managing employee has not received a set aside of the disqualification under section 245C.22;

(2) a background study must be initiated and completed for all qualified professionals; and

(3) a background study must be initiated and completed for all personal care assistants.

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Subd. 26. **Personal care assistance provider agency; communicable disease prevention.** A personal care assistance provider agency shall establish and implement policies and procedures for prevention, control, and investigation of infections and communicable diseases according to current nationally recognized infection control practices or guidelines established by the United States Centers for Disease Control and Prevention, as well as applicable regulations of other federal or state agencies.

Subd. 27. **Personal care assistance provider agency.** (a) The personal care assistance provider agency is required to provide training for the personal care assistant responsible for working with a recipient who is ventilator dependent. All training must be administered by a respiratory therapist, nurse, or physician. Qualified professional supervision by a nurse must be completed and documented on file in the personal care assistant's employment record and the recipient's health record. If offering personal care services to a ventilator-dependent recipient, the personal care assistance provider agency shall demonstrate and document the ability to:

(1) train the personal care assistant;

(2) supervise the personal care assistant in the care of a ventilator-dependent recipient;

(3) supervise the recipient and responsible party in the care of a ventilator-dependent recipient; and

(4) provide documentation of the training and supervision in clauses (1) to (3) upon request.

(b) A personal care assistant shall not undertake any clinical services, patient assessment, patient evaluation, or clinical education regarding the ventilator or the patient on the ventilator. These services may only be provided by health care professionals licensed or registered in this state.

(c) A personal care assistant may only perform tasks associated with ventilator maintenance that are approved by the Board of Medical Practice in consultation with the Respiratory Care Practitioner Advisory Council and the Department of Human Services.

Subd. 28. **Personal care assistance provider agency; required documentation.** (a) Required documentation must be completed and kept in the personal care assistance provider agency file or the recipient's home residence. The required documentation consists of:

(1) employee files, including:

(i) applications for employment;

(ii) background study requests and results;

(iii) orientation records about the agency policies;

(iv) trainings completed with demonstration of competence;

(v) supervisory visits;

(vi) evaluations of employment; and

(vii) signature on fraud statement;

(2) recipient files, including:

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(i) demographics;

(ii) emergency contact information and emergency backup plan;

(iii) personal care assistance service plan;

(iv) personal care assistance care plan;

(v) month-to-month service use plan;

(vi) all communication records;

(vii) start of service information, including the written agreement with recipient; and

(viii) date the home care bill of rights was given to the recipient;

(3) agency policy manual, including:

(i) policies for employment and termination;

(ii) grievance policies with resolution of consumer grievances;

(iii) staff and consumer safety;

(iv) staff misconduct; and

(v) staff hiring, service delivery, staff and consumer safety, staff misconduct, and resolution of consumer grievances;

(4) time sheets for each personal care assistant along with completed activity sheets for each recipient served; and

(5) agency marketing and advertising materials and documentation of marketing activities and costs.

(b) The commissioner may assess a fine of up to $500 on provider agencies that do not consistently comply with the requirements of this subdivision.

Subd. 29. **Transitional assistance.** The commissioner, counties, health plans, tribes, and personal care assistance providers shall work together to provide transitional assistance for recipients and families to come into compliance with the new requirements of this section that may require a change in living arrangement no later than August 10, 2010.

Subd. 30. **Notice of service changes to recipients.** The commissioner must provide:

(1) by October 31, 2009, information to recipients likely to be affected that (i) describes the changes to the personal care assistance program that may result in the loss of access to personal care assistance services, and (ii) includes resources to obtain further information; and

(2) a service agreement authorizing personal care assistance hours of service at the previously authorized level, throughout the appeal process period, when a recipient requests services pending an appeal.

Subd. 31. **Commissioner's access.** When the commissioner is investigating a possible overpayment of Medicaid funds, the commissioner must be given immediate access without prior notice to the office during

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regular business hours and to documentation and records related to services provided and submission of claims for services provided. Denying the commissioner access to records is cause for immediate suspension of payment and/or terminating the personal care provider organization's enrollment according to section 256B.064.

History: *1986 c 444; 1990 c 568 art 3 s 51; 1991 c 292 art 7 s 12,25; 1992 c 391 s 3-6; 1992 c 464 art 2 s 1; 1992 c 513 art 7 s 50; 1Sp1993 c 1 art 5 s 51-53; 1995 c 207 art 6 s 52-55; 1996 c 451 art 5 s 17-20; 1997 c 203 art 4 s 28,29; 3Sp1997 c 3 s 9; 1998 c 407 art 4 s 29-31; 1999 c 245 art 4 s 50-58; 2000 c 474 s 8-11; 1Sp2001 c 9 art 3 s 29-41; 2002 c 375 art 2 s 17; 2002 c 379 art 1 s 113; 2003 c 15 art 1 s 33; 1Sp2003 c 14 art 3 s 26-28; 2005 c 10 art 1 s 49,50; 1Sp2005 c 4 art 7 s 15-19; 2007 c 147 art 6 s 19-22; art 7 s 9-11; 2008 c 286 art 1 s 7; 2009 c 79 art 8 s 27,31,85; 2009 c 173 art 1 s 23-27; 2010 c 352 art 1 s 10-15; art 2 s 2-14; 2010 c 382 s 49; 1Sp2010 c 1 art 15 s 7; art 17 s 10; 1Sp2011 c 9 art 7 s 10,11; 2012 c 216 art 9 s 12-22; art 11 s 2-5; 2012 c 247 art 4 s 18,19; 2013 c 63 s 8,9; 2013 c 108 art 5 s 11; 2014 c 291 art 8 s 6,7; art 10 s 3*

256B.07 [Repealed, 1987 c 403 art 2 s 164]

256B.071 Subdivision 1. [Repealed, 2009 c 79 art 8 s 86]

Subd. 2. [Repealed, 2009 c 79 art 8 s 86]

Subd. 3. [Repealed, 2009 c 79 art 8 s 86]

Subd. 4. [Repealed, 2009 c 79 art 8 s 86]

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

256B.0711 QUALITY SELF-DIRECTED SERVICES WORKFORCE.

Subdivision 1. **Definitions.** For purposes of this section:

(a) "Commissioner" means the commissioner of human services unless otherwise indicated.

(b) "Covered program" means a program to provide direct support services funded in whole or in part by the state of Minnesota, including the Community First Services and Supports program; Consumer Directed Community Supports services and extended state plan personal care assistance services available under programs established pursuant to home and community-based service waivers authorized under section 1915(c) of the Social Security Act, and Minnesota Statutes, including, but not limited to, sections 256B.0915, 256B.092, and 256B.49, and under the alternative care program, as offered pursuant to section 256B.0913; the personal care assistance choice program, as established pursuant to section 256B.0659, subdivisions 18 to 20; and any similar program that may provide similar services in the future.

(c) "Direct support services" means personal care assistance services covered by medical assistance under section 256B.0625, subdivisions 19a and 19c; assistance with activities of daily living as defined in section 256B.0659, subdivision 1, paragraph (b), and instrumental activities of daily living as defined in section 256B.0659, subdivision 1, paragraph (i); and other similar, in-home, nonprofessional long-term services and supports provided to an elderly person or person with a disability by the person's employee or the employee of the person's representative to meet such person's daily living needs and ensure that such person may adequately function in the person's home and have safe access to the community.

(d) "Individual provider" means an individual selected by and working under the direction of a participant in a covered program, or a participant's representative, to provide direct support services to the

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participant, but does not include an employee of a provider agency, subject to the agency's direction and control commensurate with agency employee status.

(e) "Participant" means a person who receives direct support services through a covered program.

(f) "Participant's representative" means a participant's legal guardian or an individual having the authority and responsibility to act on behalf of a participant with respect to the provision of direct support services through a covered program.

Subd. 2. **Operation of covered programs.** All covered programs shall operate consistent with this section, including by affording participants and participants' representatives within the programs of the option of receiving services through individual providers as defined in subdivision 1, paragraph (d), notwithstanding any inconsistent provision of section 256B.0659.

Subd. 3. **Use of employee workforce.** The requirement under subdivision 2 shall not restrict the state's ability to afford participants and participants' representatives within the covered programs who choose not to employ an individual provider, or are unable to do so, the option of receiving similar services through the employees of provider agencies, rather than through an individual provider.

Subd. 4. **Duties of the commissioner of human services.** (a) The commissioner shall afford to all participants within a covered program the option of employing an individual provider to provide direct support services.

(b) The commissioner shall ensure that all employment of individual providers is in conformity with this section and section 179A.54, including by modifying program operations as necessary to ensure proper classification of individual providers, to require that all relevant vendors within covered programs assist and cooperate as needed, including providers of fiscal support, fiscal intermediary, financial management, or similar services to provide support to participants and participants' representatives with regard to employing individual providers, and to otherwise fulfill the requirements of this section, including the provisions of paragraph (f).

(c) The commissioner shall:

(1) establish for all individual providers compensation rates, payment terms and practices, and any benefit terms, provided that these rates and terms may permit individual provider variations based on traditional and relevant factors otherwise permitted by law;

(2) provide for required orientation programs within three months of hire for individual providers newly hired on or after January 1, 2015, regarding their employment within the covered programs through which they provide services;

(3) have the authority to provide for relevant training and educational opportunities for individual providers, as well as for participants and participants' representatives who receive services from individual providers, including opportunities for individual providers to obtain certification documenting additional training and experience in areas of specialization;

(4) have the authority to provide for the maintenance of a public registry of individuals who have consented to be included to:

(i) provide routine, emergency, and respite referrals of qualified individual providers who have consented to be included in the registry to participants and participants' representatives;

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(ii) enable participants and participants' representatives to gain improved access to, and choice among, prospective individual providers, including by having access to information about individual providers' training, educational background, work experience, and availability for hire; and

(iii) provide for appropriate employment opportunities for individual providers and a means by which they may more easily remain available to provide services to participants within covered programs; and

(5) establish other appropriate terms and conditions of employment governing the workforce of individual providers.

(d) The commissioner's authority over terms and conditions of individual providers' employment, including compensation, payment, and benefit terms, employment opportunities within covered programs, individual provider orientation, training, and education opportunities, and the operation of public registries shall be subject to the state's obligations to meet and negotiate under chapter 179A, as modified and made applicable to individual providers under section 179A.54, and to agreements with any exclusive representative of individual providers, as authorized by chapter 179A, as modified and made applicable to individual providers under section 179A.54. Except to the extent otherwise provided by law, the commissioner shall not undertake activities in paragraph (c), clauses (3) and (4), prior to July 1, 2015, unless included in a negotiated agreement and an appropriation has been provided by the legislature to the commissioner.

(e) The commissioner shall cooperate in the implementation of section 179A.54 with the commissioner of management and budget in the same manner as would be required of an appointing authority under section 179A.22 with respect to any negotiations between the executive branch of the state and the exclusive representative of individual providers, as authorized under sections 179A.22 and 179A.54. Any entity providing relevant services within covered programs, including providers of fiscal support, fiscal intermediary, financial management, or similar services to provide support to participants and participants' representatives with regard to employing individual providers shall assist and cooperate with the commissioner of human services in the operations of this section, including with respect to the commissioner's obligations under paragraphs (b) and (f).

(f) The commissioner shall, no later than September 1, 2013, and then monthly thereafter, compile and maintain a list of the names and addresses of all individual providers who have been paid for providing direct support services to participants within the previous six months. The list shall not include the name of any participant, or indicate that an individual provider is a relative of a participant or has the same address as a participant. The commissioner shall share the lists with others as needed for the state to meet its obligations under chapter 179A as modified and made applicable to individual providers under section 179A.54, and to facilitate the representational processes under section 179A.54, subdivisions 9 and 10. In order to effectuate this section and section 179A.54, questions of employee organization access to other relevant data on individual providers relating to their employment or prospective employment within covered programs shall be governed by chapter 179A and section 13.43, and shall be treated the same as labor organization access to personnel data under section 13.43, subdivision 6. This shall not include access to private data on participants or participants' representatives. Nothing in this section or section 179A.54 shall alter the access rights of other private parties to data on individual providers.

(g) The commissioner shall immediately commence all necessary steps to ensure that services offered under all covered programs are offered in conformity with this section, to gather all information that may be needed for promptly compiling lists required under this section, including information from current vendors within covered programs, and to complete any required modifications to currently operating covered programs by September 1, 2013.

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(h) Beginning January 1, 2014, the commissioner of human services shall specifically require that any fiscal support, fiscal intermediary, financial management, or similar entities providing payroll assistance services with respect to individual providers shall make all needed deductions on behalf of the state of dues check off amounts or fair-share fees for the exclusive representative, as provided in section 179A.06, subdivisions 3 and 6. All contracts with entities for the provision of payroll-related services shall include this requirement.

History: *2013 c 128 art 2 s 2,4; 2014 c 262 art 5 s 6*

NOTE: This section, as added by Laws 2013, chapter 128, article 2, section 2, expires June 30, 2017, if an exclusive representative has not been certified under section 179A.54, subdivision 10, by that date; provided further that the commissioner of the Bureau of Mediation Services shall process any petition under section 179A.54, subdivision 10, pending as of June 30, 2017, and any certification of an exclusive representative resulting from a petition pending as of June 30, 2017, shall, for the purposes of this section, be treated as having occurred on the date the petition was initially filed. Laws 2013, chapter 128, article 2, section 4.

256B.072 PERFORMANCE REPORTING AND QUALITY IMPROVEMENT SYSTEM.

(a) The commissioner of human services shall establish a performance reporting system for health care providers who provide health care services to public program recipients covered under chapters 256B, 256D, and 256L, reporting separately for managed care and fee-for-service recipients.

(b) The measures used for the performance reporting system for medical groups shall include measures of care for asthma, diabetes, hypertension, and coronary artery disease and measures of preventive care services. The measures used for the performance reporting system for inpatient hospitals shall include measures of care for acute myocardial infarction, heart failure, and pneumonia, and measures of care and prevention of surgical infections. In the case of a medical group, the measures used shall be consistent with measures published by nonprofit Minnesota or national organizations that produce and disseminate health care quality measures or evidence-based health care guidelines. In the case of inpatient hospital measures, the commissioner shall appoint the Minnesota Hospital Association and Stratis Health to advise on the development of the performance measures to be used for hospital reporting. To enable a consistent measurement process across the community, the commissioner may use measures of care provided for patients in addition to those identified in paragraph (a). The commissioner shall ensure collaboration with other health care reporting organizations so that the measures described in this section are consistent with those reported by those organizations and used by other purchasers in Minnesota.

(c) The commissioner may require providers to submit information in a required format to a health care reporting organization or to cooperate with the information collection procedures of that organization. The commissioner may collaborate with a reporting organization to collect information reported and to prevent duplication of reporting.

(d) By October 1, 2007, and annually thereafter, the commissioner shall report through a public Web site the results by medical groups and hospitals, where possible, of the measures under this section, and shall compare the results by medical groups and hospitals for patients enrolled in public programs to patients enrolled in private health plans. To achieve this reporting, the commissioner may collaborate with a health care reporting organization that operates a Web site suitable for this purpose.

History: *1Sp2005 c 4 art 8 s 43*

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256B.075 DISEASE MANAGEMENT PROGRAMS.

Subdivision 1. **General.** The commissioner shall implement disease management initiatives that seek to improve patient care and health outcomes and reduce health care costs by managing the care provided to recipients with chronic conditions.

Subd. 2. **Fee-for-service.** (a) The commissioner shall develop and implement a disease management program for medical assistance and general assistance medical care recipients who are not enrolled in the prepaid medical assistance or prepaid general assistance medical care programs and who are receiving services on a fee-for-service basis. The commissioner may contract with an outside organization to provide these services.

(b) The commissioner shall seek any federal approval necessary to implement this section and to obtain federal matching funds.

(c) The commissioner shall develop and implement a pilot intensive care management program for medical assistance children with complex and chronic medical issues.

Subd. 3. **Prepaid managed care programs.** For the prepaid medical assistance, prepaid general assistance medical care, and MinnesotaCare programs, the commissioner shall ensure that contracting health plans implement disease management programs that are appropriate for Minnesota health care program recipients and have been designed by the health plan to improve patient care and health outcomes and reduce health care costs by managing the care provided to recipients with chronic conditions.

Subd. 4. [Repealed, 2014 c 262 art 2 s 18]

Subd. 5. [Repealed, 1Sp2005 c 4 art 8 s 88]

History: *2004 c 288 art 7 s 6; 1Sp2005 c 4 art 8 s 44; 2008 c 326 art 1 s 33*

256B.0751 HEALTH CARE HOMES.

Subdivision 1. **Definitions.** (a) For purposes of sections 256B.0751 to 256B.0753, the following definitions apply.

(b) "Commissioner" means the commissioner of human services.

(c) "Commissioners" means the commissioner of human services and the commissioner of health, acting jointly.

(d) "Health plan company" has the meaning provided in section 62Q.01, subdivision 4.

(e) "Personal clinician" means a physician licensed under chapter 147, a physician assistant licensed and practicing under chapter 147A, or an advanced practice nurse licensed and registered to practice under chapter 148.

(f) "State health care program" means the medical assistance, MinnesotaCare, and general assistance medical care programs.

Subd. 2. **Development and implementation of standards.** (a) By July 1, 2009, the commissioners of health and human services shall develop and implement standards of certification for health care homes

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for state health care programs. In developing these standards, the commissioners shall consider existing standards developed by national independent accrediting and medical home organizations. The standards developed by the commissioners must meet the following criteria:

(1) emphasize, enhance, and encourage the use of primary care, and include the use of primary care physicians, advanced practice nurses, and physician assistants as personal clinicians;

(2) focus on delivering high-quality, efficient, and effective health care services;

(3) encourage patient-centered care, including active participation by the patient and family or a legal guardian, or a health care agent as defined in chapter 145C, as appropriate in decision making and care plan development, and providing care that is appropriate to the patient's race, ethnicity, and language;

(4) provide patients with a consistent, ongoing contact with a personal clinician or team of clinical professionals to ensure continuous and appropriate care for the patient's condition;

(5) ensure that health care homes develop and maintain appropriate comprehensive care plans for their patients with complex or chronic conditions, including an assessment of health risks and chronic conditions;

(6) enable and encourage utilization of a range of qualified health care professionals, including dedicated care coordinators, in a manner that enables providers to practice to the fullest extent of their license;

(7) focus initially on patients who have or are at risk of developing chronic health conditions;

(8) incorporate measures of quality, resource use, cost of care, and patient experience;

(9) ensure the use of health information technology and systematic follow-up, including the use of patient registries; and

(10) encourage the use of scientifically based health care, patient decision-making aids that provide patients with information about treatment options and their associated benefits, risks, costs, and comparative outcomes, and other clinical decision support tools.

(b) In developing these standards, the commissioners shall consult with national and local organizations working on health care home models, physicians, relevant state agencies, health plan companies, hospitals, other providers, patients, and patient advocates. The commissioners may satisfy this requirement by continuing the provider directed care coordination advisory committee.

(c) For the purposes of developing and implementing these standards, the commissioners may use the expedited rulemaking process under section 14.389.

Subd. 3. **Requirements for clinicians certified as health care homes.** (a) A personal clinician or a primary care clinic may be certified as a health care home. If a primary care clinic is certified, all of the primary care clinic's clinicians must meet the criteria of a health care home. In order to be certified as a health care home, a clinician or clinic must meet the standards set by the commissioners in accordance with this section. Certification as a health care home is voluntary. In order to maintain their status as health care homes, clinicians or clinics must renew their certification annually.

(b) Clinicians or clinics certified as health care homes must offer their health care home services to all their patients with complex or chronic health conditions who are interested in participation.

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(c) Health care homes must participate in the health care home collaborative established under subdivision 5.

Subd. 4. **Alternative models and waivers of requirements.** (a) Nothing in this section shall preclude the continued development of existing medical or health care home projects currently operating or under development by the commissioner of human services or preclude the commissioner from establishing alternative models and payment mechanisms for persons who are enrolled in integrated Medicare and Medicaid programs under section 256B.69, subdivisions 23 and 28, are enrolled in managed care long-term care programs under section 256B.69, subdivision 6b, are dually eligible for Medicare and medical assistance, are in the waiting period for Medicare, or who have other primary coverage.

(b) The commissioner of health shall waive health care home certification requirements if an applicant demonstrates that compliance with a certification requirement will create a major financial hardship or is not feasible, and the applicant establishes an alternative way to accomplish the objectives of the certification requirement.

Subd. 5. **Health care home collaborative.** By July 1, 2009, the commissioners shall establish a health care home collaborative to provide an opportunity for health care homes and state agencies to exchange information related to quality improvement and best practices.

Subd. 6. **Evaluation and continued development.** (a) For continued certification under this section, health care homes must meet process, outcome, and quality standards as developed and specified by the commissioners. The commissioners shall collect data from health care homes necessary for monitoring compliance with certification standards and for evaluating the impact of health care homes on health care quality, cost, and outcomes.

(b) The commissioners may contract with a private entity to perform an evaluation of the effectiveness of health care homes. Data collected under this subdivision is classified as nonpublic data under chapter 13.

Subd. 7. **Outreach.** Beginning July 1, 2009, the commissioner shall encourage state health care program enrollees who have a complex or chronic condition to select a primary care clinic with clinicians who have been certified as health care homes.

Subd. 8. **Coordination with local services.** The health care home and the county shall coordinate care and services provided to patients enrolled with a health care home who have complex medical needs or a disability, and who need and are eligible for additional local services administered by counties, including but not limited to waivered services, mental health services, social services, public health services, transportation, and housing. The coordination of care and services must be as provided in the plan established by the patient and health care home.

Subd. 9. **Pediatric care coordination.** The commissioner shall implement a pediatric care coordination service for children with high-cost medical or high-cost psychiatric conditions who are at risk of recurrent hospitalization or emergency room use for acute, chronic, or psychiatric illness, who receive medical assistance services. Care coordination services must be targeted to children not already receiving care coordination through another service and may include but are not limited to the provision of health care home services to children admitted to hospitals that do not currently provide care coordination. Care coordination services must be provided by care coordinators who are directly linked to provider teams in the care delivery setting, but who may be part of a community care team shared by multiple primary care providers or practices. For purposes of this subdivision, the commissioner shall, to the extent possible, use the existing health care home certification and payment structure established under this section and section 256B.0753.

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Subd. 10. **Health care homes advisory committee.** (a) The commissioners of health and human services shall establish a health care homes advisory committee to advise the commissioners on the ongoing statewide implementation of the health care homes program authorized in this section.

(b) The commissioners shall establish an advisory committee that includes representatives of the health care professions such as primary care providers; mental health providers; nursing and care coordinators; certified health care home clinics with statewide representation; health plan companies; state agencies; employers; academic researchers; consumers; and organizations that work to improve health care quality in Minnesota. At least 25 percent of the committee members must be consumers or patients in health care homes. The commissioners, in making appointments to the committee, shall ensure geographic representation of all regions of the state.

(c) The advisory committee shall advise the commissioners on ongoing implementation of the health care homes program, including, but not limited to, the following activities:

(1) implementation of certified health care homes across the state on performance management and implementation of benchmarking;

(2) implementation of modifications to the health care homes program based on results of the legislatively mandated health care homes evaluation;

(3) statewide solutions for engagement of employers and commercial payers;

(4) potential modifications of the health care homes rules or statutes;

(5) consumer engagement, including patient and family-centered care, patient activation in health care, and shared decision making;

(6) oversight for health care homes subject matter task forces or workgroups; and

(7) other related issues as requested by the commissioners.

(d) The advisory committee shall have the ability to establish subcommittees on specific topics. The advisory committee is governed by section 15.059. Notwithstanding section 15.059, the advisory committee does not expire.

History: *2008 c 358 art 2 s 1; 2009 c 159 s 91; 1Sp2011 c 9 art 6 s 54,55; 2012 c 247 art 1 s 11; 2014 c 312 art 24 s 36*

256B.0752 HEALTH CARE HOME REPORTING REQUIREMENTS.

Subdivision 1. **Annual reports on implementation and administration.** The commissioners shall report annually to the legislature on the implementation and administration of the health care home model for state health care program enrollees in the fee-for-service, managed care, and county-based purchasing sectors beginning December 15, 2009, and each December 15 thereafter.

Subd. 2. **Evaluation reports.** The commissioners shall provide to the legislature comprehensive evaluations of the health care home model three years and five years after implementation. The report must include:

(1) the number of state health care program enrollees in health care homes and the number and characteristics of enrollees with complex or chronic conditions, identified by income, race, ethnicity, and language;

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(2) the number and geographic distribution of health care home providers;

(3) the performance and quality of care of health care homes;

(4) measures of preventive care;

(5) health care home payment arrangements, and costs related to implementation and payment of care coordination fees;

(6) the estimated impact of health care homes on health disparities; and

(7) estimated savings from implementation of the health care home model for the fee-for-service, managed care, and county-based purchasing sectors.

History: *2008 c 358 art 2 s 2*

256B.0753 PAYMENT RESTRUCTURING; CARE COORDINATION PAYMENTS.

Subdivision 1. **Development.** The commissioner of human services, in coordination with the commissioner of health, shall develop a payment system that provides per-person care coordination payments to health care homes certified under section 256B.0751 for providing care coordination services and directly managing on-site or employing care coordinators. The care coordination payments under this section are in addition to the quality incentive payments in section 256B.0754, subdivision 1. The care coordination payment system must vary the fees paid by thresholds of care complexity, with the highest fees being paid for care provided to individuals requiring the most intensive care coordination. In developing the criteria for care coordination payments, the commissioner shall consider the feasibility of including the additional time and resources needed by patients with limited English-language skills, cultural differences, or other barriers to health care. The commissioner may determine a schedule for phasing in care coordination fees such that the fees will be applied first to individuals who have, or are at risk of developing, complex or chronic health conditions. Development of the payment system must be completed by January 1, 2010.

Subd. 2. **Implementation.** The commissioner of human services shall implement care coordination payments as specified under this section by July 1, 2010, or upon federal approval, whichever is later. For enrollees served under the fee-for-service system, the care coordination payment shall be determined by the commissioner in contracts with certified health care homes. For enrollees served by managed care or county-based purchasing plans, the commissioner's contracts with these plans shall require the payment of care coordination fees to certified health care homes.

Subd. 3. **Cost neutrality.** If initial savings from implementation of health care homes are not sufficient to allow implementation of the care coordination fee in a cost-neutral manner, the commissioner may make recommendations to the legislature on reallocating costs within the health care system.

History: *2008 c 358 art 2 s 3*

256B.0754 PAYMENT REFORM.

Subdivision 1. **Quality incentive payments.** By July 1, 2010, the commissioner of human services shall implement quality incentive payments as established under section 62U.02 for all enrollees in state health care programs consistent with relevant state and federal statute and rule. This section does not limit the ability of the commissioner of human services to establish by contract and monitor, as part of its quality assurance obligations for state health care programs, outcome and performance measures for nonmedical

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services and health issues likely to occur in low-income populations or racial or cultural groups disproportionately represented in state health care program enrollment that would likely be underrepresented when using traditional measures that are based on longer-term enrollment.

Subd. 2. **Payment reform.** By no later than 12 months after the commissioner of health publishes the information in section 62U.04, subdivision 3c, paragraph (b), the commissioner of human services may use the information and methods developed under section 62U.04 to establish a payment system that:

(1) rewards high-quality, low-cost providers;

(2) creates enrollee incentives to receive care from high-quality, low-cost providers; and

(3) fosters collaboration among providers to reduce cost shifting from one part of the health continuum to another.

History: *2008 c 358 art 2 s 4; 2010 c 344 s 3; 2012 c 164 s 8*

256B.0755 HEALTH CARE DELIVERY SYSTEMS DEMONSTRATION PROJECT.

Subdivision 1. **Implementation.** (a) The commissioner shall develop and authorize a demonstration project to test alternative and innovative health care delivery systems, including accountable care organizations that provide services to a specified patient population for an agreed-upon total cost of care or risk/gain sharing payment arrangement. The commissioner shall develop a request for proposals for participation in the demonstration project in consultation with hospitals, primary care providers, health plans, and other key stakeholders.

(b) In developing the request for proposals, the commissioner shall:

(1) establish uniform statewide methods of forecasting utilization and cost of care for the appropriate Minnesota public program populations, to be used by the commissioner for the health care delivery system projects;

(2) identify key indicators of quality, access, patient satisfaction, and other performance indicators that will be measured, in addition to indicators for measuring cost savings;

(3) allow maximum flexibility to encourage innovation and variation so that a variety of provider collaborations are able to become health care delivery systems;

(4) encourage and authorize different levels and types of financial risk;

(5) encourage and authorize projects representing a wide variety of geographic locations, patient populations, provider relationships, and care coordination models;

(6) encourage projects that involve close partnerships between the health care delivery system and counties and nonprofit agencies that provide services to patients enrolled with the health care delivery system, including social services, public health, mental health, community-based services, and continuing care;

(7) encourage projects established by community hospitals, clinics, and other providers in rural communities;

(8) identify required covered services for a total cost of care model or services considered in whole or partially in an analysis of utilization for a risk/gain sharing model;

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(9) establish a mechanism to monitor enrollment;

(10) establish quality standards for the delivery system demonstrations; and

(11) encourage participation of privately insured population so as to create sufficient alignment in demonstration systems.

(c) To be eligible to participate in the demonstration project, a health care delivery system must:

(1) provide required covered services and care coordination to recipients enrolled in the health care delivery system;

(2) establish a process to monitor enrollment and ensure the quality of care provided;

(3) in cooperation with counties and community social service agencies, coordinate the delivery of health care services with existing social services programs;

(4) provide a system for advocacy and consumer protection; and

(5) adopt innovative and cost-effective methods of care delivery and coordination, which may include the use of allied health professionals, telemedicine, patient educators, care coordinators, and community health workers.

(d) A health care delivery system demonstration may be formed by the following groups of providers of services and suppliers if they have established a mechanism for shared governance:

(1) professionals in group practice arrangements;

(2) networks of individual practices of professionals;

(3) partnerships or joint venture arrangements between hospitals and health care professionals;

(4) hospitals employing professionals; and

(5) other groups of providers of services and suppliers as the commissioner determines appropriate.

A managed care plan or county-based purchasing plan may participate in this demonstration in collaboration with one or more of the entities listed in clauses (1) to (5).

A health care delivery system may contract with a managed care plan or a county-based purchasing plan to provide administrative services, including the administration of a payment system using the payment methods established by the commissioner for health care delivery systems.

(e) The commissioner may require a health care delivery system to enter into additional third-party contractual relationships for the assessment of risk and purchase of stop loss insurance or another form of insurance risk management related to the delivery of care described in paragraph (c).

Subd. 2. **Enrollment.** (a) Individuals eligible for medical assistance or MinnesotaCare shall be eligible for enrollment in a health care delivery system.

(b) Eligible applicants and recipients may enroll in a health care delivery system if a system serves the county in which the applicant or recipient resides. If more than one health care delivery system serves a

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county, the applicant or recipient shall be allowed to choose among the delivery systems. The commissioner may assign an applicant or recipient to a health care delivery system if a health care delivery system is available and no choice has been made by the applicant or recipient.

Subd. 3. **Accountability.** (a) Health care delivery systems must accept responsibility for the quality of care based on standards established under subdivision 1, paragraph (b), clause (10), and the cost of care or utilization of services provided to its enrollees under subdivision 1, paragraph (b), clause (1).

(b) A health care delivery system may contract and coordinate with providers and clinics for the delivery of services and shall contract with community health clinics, federally qualified health centers, community mental health centers or programs, county agencies, and rural clinics to the extent practicable.

(c) A health care delivery system must indicate how it will coordinate with other services affecting its patients' health, quality of care, and cost of care that are provided by other providers, county agencies, and other organizations in the local service area. The health care delivery system must indicate how it will engage other providers, counties, and organizations, including county-based purchasing plans, that provide services to patients of the health care delivery system on issues related to local population health, including applicable local needs, priorities, and public health goals. The health care delivery system must describe how local providers, counties, organizations, including county-based purchasing plans, and other relevant purchasers were consulted in developing the application to participate in the demonstration project.

Subd. 4. **Payment system.** (a) In developing a payment system for health care delivery systems, the commissioner shall establish a total cost of care benchmark or a risk/gain sharing payment model to be paid for services provided to the recipients enrolled in a health care delivery system.

(b) The payment system may include incentive payments to health care delivery systems that meet or exceed annual quality and performance targets realized through the coordination of care.

(c) An amount equal to the savings realized to the general fund as a result of the demonstration project shall be transferred each fiscal year to the health care access fund.

Subd. 5. **Outpatient prescription drug coverage.** Outpatient prescription drug coverage may be provided through accountable care organizations only if the delivery method qualifies for federal prescription drug rebates.

Subd. 6. **Federal approval.** The commissioner shall apply for any federal waivers or other federal approval required to implement this section. The commissioner shall also apply for any applicable grant or demonstration under the Patient Protection and Affordable Health Care Act, Public Law 111-148, or the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, that would further the purposes of or assist in the establishment of accountable care organizations.

Subd. 7. **Expansion.** The commissioner shall expand the demonstration project to include additional medical assistance and MinnesotaCare enrollees, and shall seek participation of Medicare in demonstration projects. The commissioner shall seek to include participation of privately insured persons and Medicare recipients in the health care delivery demonstration. As part of the demonstration expansion, the commissioner may procure the services of the health care delivery systems authorized under this section by geographic area, to supplement or replace the services provided by managed care plans operating under section 256B.69.

History: *1Sp2010 c 1 art 16 s 19; 2012 c 187 art 1 s 37; 2013 c 81 s 11; 2013 c 108 art 1 s 26*

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256B.0756 HENNEPIN AND RAMSEY COUNTIES PILOT PROGRAM.

(a) The commissioner, upon federal approval of a new waiver request or amendment of an existing demonstration, may establish a pilot program in Hennepin County or Ramsey County, or both, to test alternative and innovative integrated health care delivery networks.

(b) Individuals eligible for the pilot program shall be individuals who are eligible for medical assistance under section 256B.055 and who reside in Hennepin County or Ramsey County. The commissioner may identify individuals to be enrolled in the Hennepin County pilot program based on zip code in Hennepin County or whether the individuals would benefit from an integrated health care delivery network.

(c) Individuals enrolled in the pilot program shall be enrolled in an integrated health care delivery network in their county of residence. The integrated health care delivery network in Hennepin County shall be a network, such as an accountable care organization or a community-based collaborative care network, created by or including Hennepin County Medical Center. The integrated health care delivery network in Ramsey County shall be a network, such as an accountable care organization or community-based collaborative care network, created by or including Regions Hospital.

(d) In developing a payment system for the pilot programs, the commissioner shall establish a total cost of care for the recipients enrolled in the pilot programs that equals the cost of care that would otherwise be spent for these enrollees in the prepaid medical assistance program.

(e) The commissioner shall apply to the federal government for, or as appropriate, cooperate with counties, providers, or other entities that are applying for any applicable grant or demonstration under the Patient Protection and Affordable Health Care Act, Public Law 111-148, or the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, that would further the purposes of or assist in the creation of an integrated health care delivery network for the purposes of this subdivision, including, but not limited to, a global payment demonstration or the community-based collaborative care network grants.

History: *1Sp2010 c 1 art 16 s 20,48; 2013 c 108 art 6 s 18*

256B.0757 COORDINATED CARE THROUGH A HEALTH HOME.

Subdivision 1. **Provision of coverage.** (a) The commissioner shall provide medical assistance coverage of health home services for eligible individuals with chronic conditions who select a designated provider, a team of health care professionals, or a health team as the individual's health home.

(b) The commissioner shall implement this section in compliance with the requirements of the state option to provide health homes for enrollees with chronic conditions, as provided under the Patient Protection and Affordable Care Act, Public Law 111-148, sections 2703 and 3502. Terms used in this section have the meaning provided in that act.

Subd. 2. **Eligible individual.** An individual is eligible for health home services under this section if the individual is eligible for medical assistance under this chapter and has at least:

(1) two chronic conditions;

(2) one chronic condition and is at risk of having a second chronic condition; or

(3) one serious and persistent mental health condition.

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Subd. 3. **Health home services.** (a) Health home services means comprehensive and timely high-quality services that are provided by a health home. These services include:

(1) comprehensive care management;

(2) care coordination and health promotion;

(3) comprehensive transitional care, including appropriate follow-up, from inpatient to other settings;

(4) patient and family support, including authorized representatives;

(5) referral to community and social support services, if relevant; and

(6) use of health information technology to link services, as feasible and appropriate.

(b) The commissioner shall maximize the number and type of services included in this subdivision to the extent permissible under federal law, including physician, outpatient, mental health treatment, and rehabilitation services necessary for comprehensive transitional care following hospitalization.

Subd. 4. **Health teams.** The commissioner shall establish health teams to support the patient-centered health home and provide the services described in subdivision 3 to individuals eligible under subdivision 2. The commissioner shall apply for grants or contracts as provided under section 3502 of the Patient Protection and Affordable Care Act to establish health teams and provide capitated payments to primary care providers. For purposes of this section, "health teams" means community-based, interdisciplinary, interprofessional teams of health care providers that support primary care practices. These providers may include medical specialists, nurses, advanced practice registered nurses, pharmacists, nutritionists, social workers, behavioral and mental health providers, doctors of chiropractic, licensed complementary and alternative medicine practitioners, and physician assistants.

Subd. 5. **Payments.** The commissioner shall make payments to each health home and each health team for the provision of health home services to each eligible individual with chronic conditions that selects the health home as a provider.

Subd. 6. **Coordination.** The commissioner, to the extent feasible, shall ensure that the requirements and payment methods for health homes and health teams developed under this section are consistent with the requirements and payment methods for health care homes established under sections 256B.0751 and 256B.0753. The commissioner may modify requirements and payment methods under sections 256B.0751 and 256B.0753 in order to be consistent with federal health home requirements and payment methods.

Subd. 7. [Repealed, 2014 c 262 art 2 s 18]

History: *1Sp2010 c 1 art 22 s 2*

NOTE: This section, as added by Laws 2010, First Special Session chapter 1, article 22, section 2, is effective January 1, 2011, or upon federal approval, whichever is later. Laws 2010, First Special Session chapter 1, article 22, section 2, the effective date.

256B.08 APPLICATION.

Subdivision 1. **Application process.** An applicant for medical assistance, or a person acting in the applicant's behalf, shall file an application with a local agency in the manner and form prescribed by the state agency. When a married applicant resides in a nursing home or applies for medical assistance for nursing

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home services, the local agency shall consider an application on behalf of the applicant's spouse only upon specific request of the applicant or upon specific request of the spouse and separate filing of an application.

Subd. 2. **Expedited review for pregnant women.** A pregnant woman who may be eligible for assistance under section 256B.055, subdivision 1, must receive an appointment for eligibility determination no later than five working days from the date of her request for assistance from the local agency. The local agency shall expedite processing her application for assistance and shall make a determination of eligibility on a completed application no later than ten working days following the applicant's initial appointment. The local agency shall assist the applicant to provide all necessary information and documentation in order to process the application within the time period required under this subdivision. The state agency shall provide for the placement of applications for medical assistance in eligible provider offices, community health offices, and Women, Infants and Children (WIC) program sites.

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

Subd. 4. **Data from Social Security.** The commissioner shall accept data from the Social Security Administration in accordance with United States Code, title 42, section 1396U-5(a).

History: *Ex1967 c 16 s 8; 1Sp1981 c 2 s 15; 1986 c 444; 1988 c 689 art 2 s 146,268; 1991 c 292 art 4 s 50; 2009 c 79 art 5 s 37*

256B.09 INVESTIGATIONS.

When an application for medical assistance hereunder is filed with a county agency, such county agency shall promptly make or cause to be made such investigation as it may deem necessary. The object of such investigation shall be to ascertain the facts supporting the application made hereunder and such other information as may be required by the rules of the state agency. Upon the completion of such investigation the county agency shall promptly determine eligibility. No approval by the county agency shall be required prior to payment for medical care provided to recipients determined to be eligible pursuant to this section.

History: *Ex1967 c 16 s 9; 1973 c 717 s 19*

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

256B.0911 LONG-TERM CARE CONSULTATION SERVICES.

Subdivision 1. **Purpose and goal.** (a) The purpose of long-term care consultation services is to assist persons with long-term or chronic care needs in making care decisions and selecting support and service options that meet their needs and reflect their preferences. The availability of, and access to, information and other types of assistance, including assessment and support planning, is also intended to prevent or delay institutional placements and to provide access to transition assistance after admission. Further, the goal of these services is to contain costs associated with unnecessary institutional admissions. Long-term

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consultation services must be available to any person regardless of public program eligibility. The commissioner of human services shall seek to maximize use of available federal and state funds and establish the broadest program possible within the funding available.

(b) These services must be coordinated with long-term care options counseling provided under subdivision 4d, section 256.975, subdivisions 7 to 7c, and section 256.01, subdivision 24. The lead agency providing long-term care consultation services shall encourage the use of volunteers from families, religious organizations, social clubs, and similar civic and service organizations to provide community-based services.

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

(a) Until additional requirements apply under paragraph (b), "long-term care consultation services" means:

(1) intake for and access to assistance in identifying services needed to maintain an individual in the most inclusive environment;

(2) providing recommendations for and referrals to cost-effective community services that are available to the individual;

(3) development of an individual's person-centered community support plan;

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

(5) face-to-face long-term care consultation assessments, which may be completed in a hospital, nursing facility, intermediate care facility for persons with developmental disabilities (ICF/DDs), regional treatment centers, or the person's current or planned residence;

(6) determination of home and community-based waiver and other service eligibility as required under sections 256B.0913, 256B.0915, and 256B.49, including level of care determination for individuals who need an institutional level of care as determined under subdivision 4e, based on assessment and community support plan development, appropriate referrals to obtain necessary diagnostic information, and including an eligibility determination for consumer-directed community supports;

(7) providing recommendations for institutional placement when there are no cost-effective community services available;

(8) providing access to assistance to transition people back to community settings after institutional admission; and

(9) providing information about competitive employment, with or without supports, for school-age youth and working-age adults and referrals to the Disability Linkage Line and Disability Benefits 101 to ensure that an informed choice about competitive employment can be made. For the purposes of this subdivision, "competitive employment" means work in the competitive labor market that is performed on a full-time or part-time basis in an integrated setting, and for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

(b) Upon statewide implementation of lead agency requirements in subdivisions 2b, 2c, and 3a, "long-term care consultation services" also means:

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(1) service eligibility determination for state plan home care services identified in:

(i) section 256B.0625, subdivisions 7, 19a, and 19c;

(ii) section 256B.0657; or

(iii) consumer support grants under section 256.476;

(2) notwithstanding provisions in Minnesota Rules, parts 9525.0004 to 9525.0024, determination of eligibility for case management services available under sections 256B.0621, subdivision 2, paragraph (4), and 256B.0924 and Minnesota Rules, part 9525.0016;

(3) determination of institutional level of care, home and community-based service waiver, and other service eligibility as required under section 256B.092, determination of eligibility for family support grants under section 252.32, semi-independent living services under section 252.275, and day training and habilitation services under section 256B.092; and

(4) obtaining necessary diagnostic information to determine eligibility under clauses (2) and (3).

(c) "Long-term care options counseling" means the services provided by the linkage lines as mandated by sections 256.01, subdivision 24, and 256.975, subdivision 7, and also includes telephone assistance and follow up once a long-term care consultation assessment has been completed.

(d) "Minnesota health care programs" means the medical assistance program under chapter 256B and the alternative care program under section 256B.0913.

(e) "Lead agencies" means counties administering or tribes and health plans under contract with the commissioner to administer long-term care consultation assessment and support planning services.

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

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

Subd. 2b. **Certified assessors.** (a) Each lead agency shall use certified assessors who have completed training and the certification processes determined by the commissioner in subdivision 2c. Certified assessors shall demonstrate best practices in assessment and support planning including person-centered planning principals and have a common set of skills that must ensure consistency and equitable access to services statewide. A lead agency may choose, according to departmental policies, to contract with a qualified, certified assessor to conduct assessments and reassessments on behalf of the lead agency.

(b) Certified assessors are persons with a minimum of a bachelor's degree in social work, nursing with a public health nursing certificate, or other closely related field with at least one year of home and community-based experience, or a registered nurse without public health certification with at least two years of home and community-based experience that has received training and certification specific to assessment and consultation for long-term care services in the state.

Subd. 2c. **Assessor training and certification.** The commissioner shall develop and implement a curriculum and an assessor certification process. All existing lead agency staff designated to provide the services defined in subdivision 1a must be certified within timelines specified by the commissioner, but no sooner than six months after statewide availability of the training and certification process. The commissioner must establish the timelines for training and certification in a manner that allows lead agencies to

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most efficiently adopt the automated process established in subdivision 5. Each lead agency is required to ensure that they have sufficient numbers of certified assessors to provide long-term consultation assessment and support planning within the timelines and parameters of the service. Certified assessors are required to be recertified every three years.

Subd. 3. **Long-term care consultation team.** (a) A long-term care consultation team shall be established by the county board of commissioners. Two or more counties may collaborate to establish a joint local consultation team or teams.

(b) Certified assessors must be part of a multidisciplinary long-term care consultation team of professionals that includes public health nurses, social workers, and other professionals as defined in subdivision 2b, paragraph (b). The team is responsible for providing long-term care consultation services to all persons located in the county who request the services, regardless of eligibility for Minnesota health care programs.

(c) The commissioner shall allow arrangements and make recommendations that encourage counties and tribes to collaborate to establish joint local long-term care consultation teams to ensure that long-term care consultations are done within the timelines and parameters of the service. This includes integrated service models as required in subdivision 1, paragraph (b).

(d) Tribes and health plans under contract with the commissioner must provide long-term care consultation services as specified in the contract.

(e) The lead agency must provide the commissioner with an administrative contact for communication purposes.

Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment, services planning, or other assistance intended to support community-based living, including persons who need assessment in order to determine waiver or alternative care program eligibility, must be visited by a long-term care consultation team within 20 calendar days after the date on which an assessment was requested or recommended. Upon statewide implementation of subdivisions 2b, 2c, and 5, this requirement also applies to an assessment of a person requesting personal care assistance services and home care nursing. The commissioner shall provide at least a 90-day notice to lead agencies prior to the effective date of this requirement. Face-to-face assessments must be conducted according to paragraphs (b) to (i).

(b) The lead agency may utilize a team of either the social worker or public health nurse, or both. Upon implementation of subdivisions 2b, 2c, and 5, lead agencies shall use certified assessors to conduct the assessment. The consultation team members must confer regarding the most appropriate care for each individual screened or assessed. For a person with complex health care needs, a public health or registered nurse from the team must be consulted.

(c) The assessment must be comprehensive and include a person-centered assessment of the health, psychological, functional, environmental, and social needs of referred individuals and provide information necessary to develop a community support plan that meets the consumers needs, using an assessment form provided by the commissioner.

(d) The assessment must be conducted in a face-to-face interview with the person being assessed and the person's legal representative, and other individuals as requested by the person, who can provide information on the needs, strengths, and preferences of the person necessary to develop a community support plan that ensures the person's health and safety, but who is not a provider of service or has any financial interest in the

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provision of services. For persons who are to be assessed for elderly waiver customized living services under section 256B.0915, with the permission of the person being assessed or the person's designated or legal representative, the client's current or proposed provider of services may submit a copy of the provider's nursing assessment or written report outlining its recommendations regarding the client's care needs. The person conducting the assessment will notify the provider of the date by which this information is to be submitted. This information shall be provided to the person conducting the assessment prior to the assessment. For a person who is to be assessed for waiver services under section 256B.092 or 256B.49, with the permission of the person being assessed or the person's designated legal representative, the person's current provider of services may submit a written report outlining recommendations regarding the person's care needs prepared by a direct service employee with at least 20 hours of service to that client. The person conducting the assessment or reassessment must notify the provider of the date by which this information is to be submitted. This information shall be provided to the person conducting the assessment and the person or the person's legal representative, and must be considered prior to the finalization of the assessment or reassessment.

(e) If the person chooses to use community-based services, the person or the person's legal representative must be provided with a written community support plan within 40 calendar days of the assessment visit, regardless of whether the individual is eligible for Minnesota health care programs. The written community support plan must include:

(1) a summary of assessed needs as defined in paragraphs (c) and (d);

(2) the individual's options and choices to meet identified needs, including all available options for case management services and providers;

(3) identification of health and safety risks and how those risks will be addressed, including personal risk management strategies;

(4) referral information; and

(5) informal caregiver supports, if applicable.

For a person determined eligible for state plan home care under subdivision 1a, paragraph (b), clause (1), the person or person's representative must also receive a copy of the home care service plan developed by the certified assessor.

(f) A person may request assistance in identifying community supports without participating in a complete assessment. Upon a request for assistance identifying community support, the person must be transferred or referred to long-term care options counseling services available under sections 256.975, subdivision 7, and 256.01, subdivision 24, for telephone assistance and follow up.

(g) The person has the right to make the final decision between institutional placement and community placement after the recommendations have been provided, except as provided in section 256.975, subdivision 7a, paragraph (d).

(h) The lead agency must give the person receiving assessment or support planning, or the person's legal representative, materials, and forms supplied by the commissioner containing the following information:

(1) written recommendations for community-based services and consumer-directed options;

(2) documentation that the most cost-effective alternatives available were offered to the individual. For purposes of this clause, "cost-effective" means community services and living arrangements that cost

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the same as or less than institutional care. For an individual found to meet eligibility criteria for home and community-based service programs under section 256B.0915 or 256B.49, "cost-effectiveness" has the meaning found in the federally approved waiver plan for each program;

(3) the need for and purpose of preadmission screening conducted by long-term care options counselors according to section 256.975, subdivisions 7a to 7c, if the person selects nursing facility placement. If the individual selects nursing facility placement, the lead agency shall forward information needed to complete the level of care determinations and screening for developmental disability and mental illness collected during the assessment to the long-term care options counselor using forms provided by the commissioner;

(4) the role of long-term care consultation assessment and support planning in eligibility determination for waiver and alternative care programs, and state plan home care, case management, and other services as defined in subdivision 1a, paragraphs (a), clause (6), and (b);

(5) information about Minnesota health care programs;

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

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

(8) the certified assessor's decision regarding the person's need for institutional level of care as determined under criteria established in subdivision 4e and the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 1a, paragraphs (a), clause (6), and (b); and

(9) the person's right to appeal the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 1a, paragraphs (a), clauses (6), (7), and (8), and (b), and incorporating the decision regarding the need for institutional level of care or the lead agency's final decisions regarding public programs eligibility according to section 256.045, subdivision 3.

(i) Face-to-face assessment completed as part of eligibility determination for the alternative care, elderly waiver, community alternatives for disabled individuals, community alternative care, and brain injury waiver programs under sections 256B.0913, 256B.0915, and 256B.49 is valid to establish service eligibility for no more than 60 calendar days after the date of assessment.

(j) The effective eligibility start date for programs in paragraph (i) can never be prior to the date of assessment. If an assessment was completed more than 60 days before the effective waiver or alternative care program eligibility start date, assessment and support plan information must be updated and documented in the department's Medicaid Management Information System (MMIS). Notwithstanding retroactive medical assistance coverage of state plan services, the effective date of eligibility for programs included in paragraph (i) cannot be prior to the date the most recent updated assessment is completed.

Subd. 3b. **Transition assistance.** (a) Lead agency certified assessors shall provide assistance to persons residing in a nursing facility, hospital, regional treatment center, or intermediate care facility for persons with developmental disabilities who request or are referred for assistance. Transition assistance must include assessment, community support plan development, referrals to long-term care options counseling under section 256.975, subdivision 7, for community support plan implementation and to Minnesota health care programs, including home and community-based waiver services and consumer-directed options through the waivers, and referrals to programs that provide assistance with housing. Transition assistance must also include information about the Centers for Independent Living, Disability Linkage Line, and about other

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organizations that can provide assistance with relocation efforts, and information about contacting these organizations to obtain their assistance and support.

(b) The lead agency shall ensure that:

(1) referrals for in-person assessments are taken from long-term care options counselors as provided for in section 256.975, subdivision 7, paragraph (b), clause (11);

(2) persons assessed in institutions receive information about transition assistance that is available;

(3) the assessment is completed for persons within 20 calendar days of the date of request or recommendation for assessment;

(4) there is a plan for transition and follow-up for the individual's return to the community, including notification of other local agencies when a person may require assistance from agencies located in another county; and

(5) relocation targeted case management as defined in section 256B.0621, subdivision 2, clause (4), is authorized for an eligible medical assistance recipient.

Subd. 3c. **Consultation for housing with services.** (a) The purpose of long-term care consultation for registered housing with services is to support persons with current or anticipated long-term care needs in making informed choices among options that include the most cost-effective and least restrictive settings. Prospective residents maintain the right to choose housing with services or assisted living if that option is their preference.

(b) Registered housing with services establishments shall inform each prospective resident or the prospective resident's designated or legal representative of the availability of long-term care consultation and the need to receive and verify the consultation prior to signing a lease or contract. Long-term care consultation for registered housing with services is provided as determined by the commissioner of human services. The service is delivered under a partnership between lead agencies as defined in subdivision 1a, paragraph (d), and the Area Agencies on Aging, and is a point of entry to a combination of telephone-based long-term care options counseling provided by Senior LinkAge Line and in-person long-term care consultation provided by lead agencies. The point of entry service must be provided within five working days of the request of the prospective resident as follows:

(1) the consultation shall be conducted with the prospective resident, or in the alternative, the resident's designated or legal representative, if:

(i) the resident verbally requests; or

(ii) the registered housing with services provider has documentation of the designated or legal representative's authority to enter into a lease or contract on behalf of the prospective resident and accepts the documentation in good faith;

(2) the consultation shall be performed in a manner that provides objective and complete information;

(3) the consultation must include a review of the prospective resident's reasons for considering housing with services, the prospective resident's personal goals, a discussion of the prospective resident's immediate and projected long-term care needs, and alternative community services or housing with services settings that may meet the prospective resident's needs;

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(4) the prospective resident shall be informed of the availability of a face-to-face visit at no charge to the prospective resident to assist the prospective resident in assessment and planning to meet the prospective resident's long-term care needs; and

(5) verification of counseling shall be generated and provided to the prospective resident by Senior LinkAge Line upon completion of the telephone-based counseling.

(c) Housing with services establishments registered under chapter 144D shall:

(1) inform each prospective resident or the prospective resident's designated or legal representative of the availability of and contact information for consultation services under this subdivision;

(2) receive a copy of the verification of counseling prior to executing a lease or service contract with the prospective resident, and prior to executing a service contract with individuals who have previously entered into lease-only arrangements; and

(3) retain a copy of the verification of counseling as part of the resident's file.

(d) Emergency admissions to registered housing with services establishments prior to consultation under paragraph (b) are permitted according to policies established by the commissioner.

Subd. 3d. **Exemptions.** Individuals shall be exempt from the requirements outlined in subdivision 3c in the following circumstances:

(1) the individual is seeking a lease-only arrangement in a subsidized housing setting;

(2) the individual has previously received a long-term care consultation assessment under this section. In this instance, the assessor who completes the long-term care consultation will issue a verification code and provide it to the individual;

(3) the individual is receiving or is being evaluated for hospice services from a hospice provider licensed under sections 144A.75 to 144A.755; or

(4) the individual has used financial planning services and created a long-term care plan as defined by the commissioner in the 12 months prior to signing a lease or contract with a registered housing with services establishment.

Subd. 3e. **Consultation at hospital discharge.** (a) Hospitals shall refer all individuals described in paragraph (b) prior to discharge from an inpatient hospital stay to the Senior LinkAge Line for long-term care options counseling. Hospitals shall make these referrals using referral protocols and processes developed under section 256.975, subdivision 7. The purpose of the counseling is to support persons with current or anticipated long-term care needs in making informed choices among options that include the most cost-effective and least restrictive setting.

(b) The individuals who shall be referred under paragraph (a) include older adults who are at risk of nursing home placement. Protocols for identifying at-risk individuals shall be developed under section 256.975, subdivision 7, paragraph (b), clause (12).

(c) Counseling provided under this subdivision shall meet the requirements for the consultation required under section 256B.0911, subdivision 3c.

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

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Subd. 4a. [Repealed, 2013 c 108 art 2 s 45]

Subd. 4b. [Repealed, 2013 c 108 art 2 s 45]

Subd. 4c. [Repealed, 2013 c 108 art 2 s 45]

Subd. 4d. **Preadmission screening of individuals under 65 years of age.** (a) It is the policy of the state of Minnesota to ensure that individuals with disabilities or chronic illness are served in the most integrated setting appropriate to their needs and have the necessary information to make informed choices about home and community-based service options.

(b) Individuals under 65 years of age who are admitted to a Medicaid-certified nursing facility must be screened prior to admission according to the requirements outlined in section 256.975, subdivisions 7a to 7c. This shall be provided by the Senior LinkAge Line as required under section 256.975, subdivision 7.

(c) Individuals under 65 years of age who are admitted to nursing facilities with only a telephone screening must receive a face-to-face assessment from the long-term care consultation team member of the county in which the facility is located or from the recipient's county case manager within 40 calendar days of admission.

(d) At the face-to-face assessment, the long-term care consultation team member or county case manager must perform the activities required under subdivision 3b.

(e) For individuals under 21 years of age, a screening interview which recommends nursing facility admission must be face-to-face and approved by the commissioner before the individual is admitted to the nursing facility.

(f) In the event that an individual under 65 years of age is admitted to a nursing facility on an emergency basis, the Senior LinkAge Line must be notified of the admission on the next working day, and a face-to-face assessment as described in paragraph (c) must be conducted within 40 calendar days of admission.

(g) At the face-to-face assessment, the long-term care consultation team member or the case manager must present information about home and community-based options, including consumer-directed options, so the individual can make informed choices. If the individual chooses home and community-based services, the long-term care consultation team member or case manager must complete a written relocation plan within 20 working days of the visit. The plan shall describe the services needed to move out of the facility and a time line for the move which is designed to ensure a smooth transition to the individual's home and community.

(h) An individual under 65 years of age residing in a nursing facility shall receive a face-to-face assessment at least every 12 months to review the person's service choices and available alternatives unless the individual indicates, in writing, that annual visits are not desired. In this case, the individual must receive a face-to-face assessment at least once every 36 months for the same purposes.

(i) Notwithstanding the provisions of subdivision 6, the commissioner may pay county agencies directly for face-to-face assessments for individuals under 65 years of age who are being considered for placement or residing in a nursing facility.

(j) Funding for preadmission screening follow-up shall be provided to the Disability Linkage Line for the under-60 population by the Department of Human Services to cover options counseling salaries and expenses to provide the services described in subdivisions 7a to 7c. The Disability Linkage Line

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shall employ, or contract with other agencies to employ, within the limits of available funding, sufficient personnel to provide preadmission screening follow-up services and shall seek to maximize federal funding for the service as provided under section 256.01, subdivision 2, paragraph (dd).

Subd. 4e. **Determination of institutional level of care.** The determination of the need for nursing facility, hospital, and intermediate care facility levels of care must be made according to criteria developed by the commissioner, and in section 256B.092, using forms developed by the commissioner. Effective January 1, 2014, for individuals age 21 and older, the determination of need for nursing facility level of care shall be based on criteria in section 144.0724, subdivision 11. For individuals under age 21, the determination of the need for nursing facility level of care must be made according to criteria developed by the commissioner until criteria in section 144.0724, subdivision 11, becomes effective on or after October 1, 2019.

Subd. 5. **Administrative activity.** The commissioner shall streamline the processes, including timelines for when assessments need to be completed, required to provide the services in this section and shall implement integrated solutions to automate the business processes to the extent necessary for community support plan approval, reimbursement, program planning, evaluation, and policy development.

Subd. 6. **Payment for long-term care consultation services.** (a) Until September 30, 2013, payment for long-term care consultation face-to-face assessment shall be made as described in this subdivision.

(b) The total payment for each county must be paid monthly by certified nursing facilities in the county. The monthly amount to be paid by each nursing facility for each fiscal year must be determined by dividing the county's annual allocation for long-term care consultation services by 12 to determine the monthly payment and allocating the monthly payment to each nursing facility based on the number of licensed beds in the nursing facility. Payments to counties in which there is no certified nursing facility must be made by increasing the payment rate of the two facilities located nearest to the county seat.

(c) The commissioner shall include the total annual payment determined under paragraph (b) for each nursing facility reimbursed under section 256B.431, 256B.434, or 256B.441.

(d) In the event of the layaway, delicensure and decertification, or removal from layaway of 25 percent or more of the beds in a facility, the commissioner may adjust the per diem payment amount in paragraph (c) and may adjust the monthly payment amount in paragraph (b). The effective date of an adjustment made under this paragraph shall be on or after the first day of the month following the effective date of the layaway, delicensure and decertification, or removal from layaway.

(e) Payments for long-term care consultation services are available to the county or counties to cover staff salaries and expenses to provide the services described in subdivision 1a. The county shall employ, or contract with other agencies to employ, within the limits of available funding, sufficient personnel to provide long-term care consultation services while meeting the state's long-term care outcomes and objectives as defined in subdivision 1. The county shall be accountable for meeting local objectives as approved by the commissioner in the biennial home and community-based services quality assurance plan on a form provided by the commissioner.

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

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

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(h) Until the alternative payment methodology in paragraph (i) is implemented, the county may bill, as case management services, assessments, support planning, and follow-along provided to persons determined to be eligible for case management under Minnesota health care programs. No individual or family member shall be charged for an initial assessment or initial support plan development provided under subdivision 3a or 3b.

(i) The commissioner shall develop an alternative payment methodology, effective on October 1, 2013, for long-term care consultation services that includes the funding available under this subdivision, and for assessments authorized under sections 256B.092 and 256B.0659. In developing the new payment methodology, the commissioner shall consider the maximization of other funding sources, including federal administrative reimbursement through federal financial participation funding, for all long-term care consultation activity. The alternative payment methodology shall include the use of the appropriate time studies and the state financing of nonfederal share as part of the state's medical assistance program.

Subd. 6a. **Withholding.** If any provider obligated to pay the long-term care consultation amount as described in subdivision 6 is more than two months delinquent in the timely payment of the monthly installment, the commissioner may withhold payments, penalties, and interest in accordance with the methods outlined in section 256.9657, subdivision 7a. Any amount withheld under this provision must be returned to the county to whom the delinquent payments were due.

Subd. 7. **Reimbursement for certified nursing facilities.** (a) Medical assistance reimbursement for nursing facilities shall be authorized for a medical assistance recipient only if a preadmission screening has been conducted prior to admission or the county has authorized an exemption. Medical assistance reimbursement for nursing facilities shall not be provided for any recipient who the local screener has determined does not meet the level of care criteria for nursing facility placement in section 144.0724, subdivision 11, or, if indicated, has not had a level II OBRA evaluation as required under the federal Omnibus Budget Reconciliation Act of 1987 completed unless an admission for a recipient with mental illness is approved by the local mental health authority or an admission for a recipient with developmental disability is approved by the state developmental disability authority.

(b) The nursing facility must not bill a person who is not a medical assistance recipient for resident days that preceded the date of completion of screening activities as required under section 256.975, subdivisions 7a to 7c. The nursing facility must include unreimbursed resident days in the nursing facility resident day totals reported to the commissioner.

Subd. 8. [Repealed, 2001 c 161 s 58]

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

History: *1991 c 292 art 7 s 14; 1992 c 513 art 7 s 53-55; 1Sp1993 c 1 art 5 s 56-61,135; 1995 c 207 art 6 s 57-61; 1997 c 203 art 4 s 34; art 9 s 10; 1997 c 225 art 8 s 6; 1998 c 407 art 4 s 33-35; 1999 c 245 art 3 s 12; 1Sp2001 c 9 art 3 s 42; art 4 s 4-14; 2002 c 277 s 32; 2002 c 375 art 2 s 18,19; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 2 s 56; art 3 s 29; 2004 c 288 art 5 s 4; 2005 c 56 s 1; 2005 c 98 art 2 s 5; 1Sp2005 c 4 art 8 s 45; 2007 c 147 art 6 s 23-28; art 7 s 13,14; 2009 c 79 art 8 s 32-43; 2009 c 173 art 1 s 28; 2010 c 352 art 1 s 16-20; 1Sp2010 c 1 art 24 s 5; 1Sp2011 c 9 art 7 s 12-15; 2012 c 216 art 11 s 6-15; 2012 c 247 art 4 s 20-23; 2012 c 253 art 3 s 1; 2013 c 63 s 10; 2013 c 108 art 2 s 17-23,44,45; art 15 s 3,4; 2014 c 275 art 1 s 59; 2014 c 291 art 9 s 5*

256B.0912 [Repealed, 1Sp2001 c 9 art 3 s 76]

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256B.0913 ALTERNATIVE CARE PROGRAM.

Subdivision 1. **Purpose and goals.** The purpose of the alternative care program is to provide funding for home and community-based services for elderly persons, in order to limit nursing facility placements. The program is designed to support elderly persons in their desire to remain in the community as independently and as long as possible and to support informal caregivers in their efforts to provide care for elderly people. Further, the goals of the program are:

(1) to contain medical assistance expenditures by funding care in the community; and

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

Subd. 2. **Eligibility for services.** Alternative care services are available to Minnesotans age 65 or older who would be eligible for medical assistance within 135 days of admission to a nursing facility and subject to subdivisions 4 to 13.

Subd. 3. [Repealed, 1Sp2001 c 9 art 4 s 34]

Subd. 4. **Eligibility for funding for services for nonmedical assistance recipients.** (a) Funding for services under the alternative care program is available to persons who meet the following criteria:

(1) the person has been determined by a community assessment under section 256B.0911 to be a person who would require the level of care provided in a nursing facility, as determined under section 256B.0911, subdivision 4e, but for the provision of services under the alternative care program;

(2) the person is age 65 or older;

(3) the person would be eligible for medical assistance within 135 days of admission to a nursing facility;

(4) the person is not ineligible for the payment of long-term care services by the medical assistance program due to an asset transfer penalty under section 256B.0595 or equity interest in the home exceeding $500,000 as stated in section 256B.056;

(5) the person needs long-term care services that are not funded through other state or federal funding, or other health insurance or other third-party insurance such as long-term care insurance;

(6) except for individuals described in clause (7), the monthly cost of the alternative care services funded by the program for this person does not exceed 75 percent of the monthly limit described under section 256B.0915, subdivision 3a. This monthly limit does not prohibit the alternative care client from payment for additional services, but in no case may the cost of additional services purchased under this section exceed the difference between the client's monthly service limit defined under section 256B.0915, subdivision 3, and the alternative care program monthly service limit defined in this paragraph. If care-related supplies and equipment or environmental modifications and adaptations are or will be purchased for an alternative care services recipient, the costs may be prorated on a monthly basis for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's other alternative care services exceeds the monthly limit established in this paragraph, the annual cost of the alternative care services shall be determined. In this event, the annual cost of alternative care services shall not exceed 12 times the monthly limit described in this paragraph;

(7) for individuals assigned a case mix classification A as described under section 256B.0915, subdivision 3a, paragraph (a), with (i) no dependencies in activities of daily living, or (ii) up to two dependencies

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in bathing, dressing, grooming, walking, and eating when the dependency score in eating is three or greater as determined by an assessment performed under section 256B.0911, the monthly cost of alternative care services funded by the program cannot exceed $593 per month for all new participants enrolled in the program on or after July 1, 2011. This monthly limit shall be applied to all other participants who meet this criteria at reassessment. This monthly limit shall be increased annually as described in section 256B.0915, subdivision 3a, paragraph (a). This monthly limit does not prohibit the alternative care client from payment for additional services, but in no case may the cost of additional services purchased exceed the difference between the client's monthly service limit defined in this clause and the limit described in clause (6) for case mix classification A; and

(8) the person is making timely payments of the assessed monthly fee.

A person is ineligible if payment of the fee is over 60 days past due, unless the person agrees to:

(i) the appointment of a representative payee;

(ii) automatic payment from a financial account;

(iii) the establishment of greater family involvement in the financial management of payments; or

(iv) another method acceptable to the lead agency to ensure prompt fee payments.

The lead agency may extend the client's eligibility as necessary while making arrangements to facilitate payment of past-due amounts and future premium payments. Following disenrollment due to nonpayment of a monthly fee, eligibility shall not be reinstated for a period of 30 days.

(b) Alternative care funding under this subdivision is not available for a person who is a medical assistance recipient or who would be eligible for medical assistance without a spenddown or waiver obligation. A person whose initial application for medical assistance and the elderly waiver program is being processed may be served under the alternative care program for a period up to 60 days. If the individual is found to be eligible for medical assistance, medical assistance must be billed for services payable under the federally approved elderly waiver plan and delivered from the date the individual was found eligible for the federally approved elderly waiver plan. Notwithstanding this provision, alternative care funds may not be used to pay for any service the cost of which: (i) is payable by medical assistance; (ii) is used by a recipient to meet a waiver obligation; or (iii) is used to pay a medical assistance income spenddown for a person who is eligible to participate in the federally approved elderly waiver program under the special income standard provision.

(c) Alternative care funding is not available for a person who resides in a licensed nursing home, certified boarding care home, hospital, or intermediate care facility, except for case management services which are provided in support of the discharge planning process for a nursing home resident or certified boarding care home resident to assist with a relocation process to a community-based setting.

(d) Alternative care funding is not available for a person whose income is greater than the maintenance needs allowance under section 256B.0915, subdivision 1d, but equal to or less than 120 percent of the federal poverty guideline effective July 1 in the fiscal year for which alternative care eligibility is determined, who would be eligible for the elderly waiver with a waiver obligation.

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

(1) adult day care;

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(2) home health aide;

(3) homemaker services;

(4) personal care;

(5) case management;

(6) respite care;

(7) care-related supplies and equipment;

(8) meals delivered to the home;

(9) nonmedical transportation;

(10) nursing services;

(11) chore services;

(12) companion services;

(13) nutrition services;

(14) training for direct informal caregivers;

(15) telehome care to provide services in their own homes in conjunction with in-home visits;

(16) consumer-directed community services under the alternative care programs which are available statewide and limited to the average monthly expenditures representative of all alternative care program participants for the same case mix resident class assigned in the most recent fiscal year for which complete expenditure data is available;

(17) environmental modifications and adaptations; and

(18) discretionary services, for which lead agencies may make payment from their alternative care program allocation for services not otherwise defined in this section or section 256B.0625, following approval by the commissioner.

Total annual payments for discretionary services for all clients served by a lead agency must not exceed 25 percent of that lead agency's annual alternative care program base allocation.

Subd. 5a. **Services; service definitions; service standards.** (a) Unless specified in statute, the services, service definitions, and standards for alternative care services shall be the same as the services, service definitions, and standards specified in the federally approved elderly waiver plan, except alternative care does not cover transitional support services, assisted living services, adult foster care services, and residential care and benefits defined under section 256B.0625 that meet primary and acute health care needs.

(b) The lead agency must ensure that the funds are not used to supplant or supplement services available through other public assistance or services programs, including supplementation of client co-pays, deductibles, premiums, or other cost-sharing arrangements for health-related benefits and services or entitlement programs and services that are available to the person, but in which they have elected not to enroll. The lead agency must ensure that the benefit department recovery system in the Medicaid Management Information System (MMIS) has the necessary information on any other health insurance or third-party

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insurance policy to which the client may have access. Supplies and equipment may be purchased from a vendor not certified to participate in the Medicaid program if the cost for the item is less than that of a Medicaid vendor.

(c) Personal care services must meet the service standards defined in the federally approved elderly waiver plan, except that a lead agency may authorize services to be provided by a client's relative who meets the relative hardship waiver requirements or a relative who meets the criteria and is also the responsible party under an individual service plan that ensures the client's health and safety and supervision of the personal care services by a qualified professional as defined in section 256B.0625, subdivision 19c. Relative hardship is established by the lead agency when the client's care causes a relative caregiver to do any of the following: resign from a paying job, reduce work hours resulting in lost wages, obtain a leave of absence resulting in lost wages, incur substantial client-related expenses, provide services to address authorized, unstaffed direct care time, or meet special needs of the client unmet in the formal service plan.

Subd. 5b. [Repealed, 2007 c 147 art 7 s 76]

Subd. 5c. [Repealed, 2007 c 147 art 7 s 76]

Subd. 5d. [Repealed, 2007 c 147 art 7 s 76]

Subd. 5e. [Repealed, 2007 c 147 art 7 s 76]

Subd. 5f. [Repealed, 2007 c 147 art 7 s 76]

Subd. 5g. [Repealed, 2007 c 147 art 7 s 76]

Subd. 5h. [Repealed, 2007 c 147 art 7 s 76]

Subd. 5i. **Immunity.** The state of Minnesota, county, lead agency under contract, or tribal government under contract to administer the alternative care program shall not be liable for damages, injuries, or liabilities sustained through the purchase of direct supports or goods by the person, the person's family, or the authorized representative with funds received through the cash payments under this section. Liabilities include, but are not limited to, workers' compensation, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA).

Subd. 6. **Alternative care program administration.** (a) The alternative care program is administered by the county agency. This agency is the lead agency responsible for the local administration of the alternative care program as described in this section. However, it may contract with the public health nursing service to be the lead agency. The commissioner may contract with federally recognized Indian tribes with a reservation in Minnesota to serve as the lead agency responsible for the local administration of the alternative care program as described in the contract.

(b) Alternative care pilot projects operate according to this section and the provisions of Laws 1993, First Special Session chapter 1, article 5, section 133, under agreement with the commissioner. Each pilot project agreement period shall begin no later than the first payment cycle of the state fiscal year and continue through the last payment cycle of the state fiscal year.

Subd. 7. **Case management.** (a) The provision of case management under the alternative care program is governed by requirements in section 256B.0915, subdivisions 1a and 1b.

(b) The case manager must not approve alternative care funding for a client in any setting in which the case manager cannot reasonably ensure the client's health and safety.

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(c) The case manager is responsible for the cost-effectiveness of the alternative care individual coordinated service and support plan and must not approve any plan in which the cost of services funded by alternative care and client contributions exceeds the limit specified in section 256B.0915, subdivision 3a, paragraphs (a) and (c).

(d) Case manager responsibilities include those in section 256B.0915, subdivision 1a, paragraph (g).

Subd. 8. **Requirements for individual coordinated service and support plan.** (a) The case manager shall implement the coordinated service and support plan for each alternative care client and ensure that a client's service needs and eligibility are reassessed at least every 12 months. The coordinated service and support plan must meet the requirements in section 256B.0915, subdivision 6. The plan shall include any services prescribed by the individual's attending physician as necessary to allow the individual to remain in a community setting. In developing the individual's care plan, the case manager should include the use of volunteers from families and neighbors, religious organizations, social clubs, and civic and service organizations to support the formal home care services. The lead agency shall be held harmless for damages or injuries sustained through the use of volunteers under this subdivision including workers' compensation liability. The case manager shall provide documentation in each individual's plan and, if requested, to the commissioner that the most cost-effective alternatives available have been offered to the individual and that the individual was free to choose among available qualified providers, both public and private, including qualified case management or service coordination providers other than those employed by any county; however, the county or tribe maintains responsibility for prior authorizing services in accordance with statutory and administrative requirements. The case manager must give the individual a ten-day written notice of any denial, termination, or reduction of alternative care services.

(b) The county of service or tribe must provide access to and arrange for case management services, including assuring implementation of the coordinated service and support plan. "County of service" has the meaning given it in Minnesota Rules, part 9505.0015, subpart 11. The county of service must notify the county of financial responsibility of the approved care plan and the amount of encumbered funds.

Subd. 9. [Repealed, 2014 c 262 art 4 s 9]

Subd. 10. **Allocation formula.** (a) By July 15 of each year, the commissioner shall allocate to county agencies the state funds available for alternative care for persons eligible under subdivision 2.

(b) The adjusted base for each lead agency is the lead agency's current fiscal year base allocation plus any targeted funds approved during the current fiscal year. Calculations for paragraphs (c) and (d) are to be made as follows: for each lead agency, the determination of alternative care program expenditures shall be based on payments for services rendered from April 1 through March 31 in the base year, to the extent that claims have been submitted and paid by June 1 of that year.

(c) If the alternative care program expenditures as defined in paragraph (b) are 95 percent or more of the lead agency's adjusted base allocation, the allocation for the next fiscal year is 100 percent of the adjusted base, plus inflation to the extent that inflation is included in the state budget.

(d) If the alternative care program expenditures as defined in paragraph (b) are less than 95 percent of the lead agency's adjusted base allocation, the allocation for the next fiscal year is the adjusted base allocation less the amount of unspent funds below the 95 percent level.

(e) If the annual legislative appropriation for the alternative care program is inadequate to fund the combined lead agency allocations for a biennium, the commissioner shall distribute to each lead agency the

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entire annual appropriation as that lead agency's percentage of the computed base as calculated in paragraphs (c) and (d).

(f) On agreement between the commissioner and the lead agency, the commissioner may have discretion to reallocate alternative care base allocations distributed to lead agencies in which the base amount exceeds program expenditures.

Subd. 11. **Targeted funding.** (a) The purpose of targeted funding is to make additional money available to lead agencies with the greatest need. Targeted funds are not intended to be distributed equitably among all lead agencies, but rather, allocated to those with long-term care strategies that meet state goals.

(b) The funds available for targeted funding shall be the total appropriation for each fiscal year minus lead agency allocations determined under subdivision 10 as adjusted for any inflation increases provided in appropriations for the biennium.

(c) The commissioner shall allocate targeted funds to lead agencies that demonstrate to the satisfaction of the commissioner that they have developed feasible plans to increase alternative care spending. In making targeted funding allocations, the commissioner shall use the following priorities:

(1) lead agencies that received a lower allocation in fiscal year 1991 than in fiscal year 1990. Counties remain in this priority until they have been restored to their fiscal year 1990 level plus inflation;

(2) lead agencies that sustain a base allocation reduction for failure to spend 95 percent of the allocation if they demonstrate that the base reduction should be restored;

(3) lead agencies that propose projects to divert community residents from nursing home placement or convert nursing home residents to community living; and

(4) lead agencies that can otherwise justify program growth by demonstrating the existence of waiting lists, demographically justified needs, or other unmet needs.

(d) Lead agencies that would receive targeted funds according to paragraph (c) must demonstrate to the commissioner's satisfaction that the funds would be appropriately spent by showing how the funds would be used to further the state's alternative care goals as described in subdivision 1, and that the county has the administrative and service delivery capability to use them.

(e) The commissioner shall make applications available for targeted funds by November 1 of each year. The lead agencies selected for targeted funds shall be notified of the amount of their additional funding. Targeted funds allocated to a lead agency in one year shall be treated as part of the lead agency's base allocation for that year in determining allocations for subsequent years. No reallocations between lead agencies shall be made.

Subd. 12. **Client fees.** (a) A fee is required for all alternative care eligible clients to help pay for the cost of participating in the program. The amount of the fee 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 less than 100 percent of the federal poverty guideline effective on July 1 of the state fiscal year in which the fee is being computed, and total assets are less than $10,000, the fee is zero;

(2) when the alternative care client's income less recurring and predictable medical expenses is equal to or greater than 100 percent but less than 150 percent of the federal poverty guideline effective on July

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1 of the state fiscal year in which the fee is being computed, and total assets are less than $10,000, the fee is five percent of the cost of alternative care services;

(3) when the alternative care client's income less recurring and predictable medical expenses is equal to or greater than 150 percent but less than 200 percent of the federal poverty guidelines effective on July 1 of the state fiscal year in which the fee is being computed and assets are less than $10,000, the fee is 15 percent of the cost of alternative care services;

(4) when the alternative care client's income less recurring and predictable medical expenses is equal to or greater than 200 percent of the federal poverty guidelines effective on July 1 of the state fiscal year in which the fee is being computed and assets are less than $10,000, the fee is 30 percent of the cost of alternative care services; and

(5) when the alternative care client's assets are equal to or greater than $10,000, the fee is 30 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 shall be included in the estimated costs for the purpose of determining the fee.

Fees are due and payable each month alternative care services are received unless the actual cost of the services is less than the fee, in which case the fee is the lesser amount.

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

(1) a person is residing in a nursing facility;

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

(3) a person is found eligible for alternative care, but is not yet receiving alternative care services including case management services; or

(4) a person has chosen to participate in a consumer-directed service plan for which the cost is no greater than the total cost of the person's alternative care service plan less the monthly fee amount that would otherwise be assessed.

(c) The commissioner will bill and collect the fee from the client. Money collected must be deposited in the general fund and is appropriated to the commissioner for the alternative care program. The client must supply the lead agency with the client's Social Security number at the time of application. The lead agency shall supply the commissioner with the client's Social Security number and other information the commissioner requires to collect the fee from the client. The commissioner shall collect unpaid fees using the Revenue Recapture Act in chapter 270A and other methods available to the commissioner. The commissioner may require lead agencies to inform clients of the collection procedures that may be used by the state if a fee is not paid.

Subd. 13. **Lead agency biennial plan.** The lead agency biennial plan for long-term care consultation services under section 256B.0911, the alternative care program under this section, and waivers for the elderly under section 256B.0915, shall be submitted by the lead agency as the home and community-based services quality assurance plan on a form provided by the commissioner.

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Subd. 14. **Provider requirements, payment, and rate adjustments.** (a) Unless otherwise specified in statute, providers must be enrolled as Minnesota health care program providers and abide by the requirements for provider participation according to Minnesota Rules, part 9505.0195.

(b) Payment for provided alternative care services as approved by the client's case manager shall occur through the invoice processing procedures of the department's Medicaid Management Information System (MMIS). To receive payment, the lead agency or vendor must submit invoices within 12 months following the date of service. The lead agency and its vendors shall not be reimbursed for services which exceed the county allocation. Service rates are governed by section 256B.0915, subdivision 3g.

Subd. 15. [Repealed, 1998 c 407 art 4 s 69]

Subd. 15a. [Repealed, 1Sp2001 c 9 art 4 s 34]

Subd. 15b. [Repealed, 1Sp2001 c 9 art 4 s 34]

Subd. 15c. [Repealed, 1Sp2001 c 9 art 4 s 34]

Subd. 16. [Repealed, 1Sp2001 c 9 art 4 s 34]

History: *1991 c 292 art 7 s 15; 1992 c 464 art 2 s 1; 1992 c 513 art 7 s 56-61; 1Sp1993 c 1 art 5 s 62-67; 1Sp1993 c 6 s 12; 1995 c 207 art 6 s 63-69; art 9 s 60; 1995 c 263 s 8; 1996 c 451 art 2 s 23-25; art 4 s 70; art 5 s 21,22; 1997 c 113 s 17; 1997 c 203 art 4 s 36-39; art 11 s 6; 1997 c 225 art 8 s 3; 1998 c 407 art 4 s 36; 1999 c 245 art 3 s 13-16; 2000 c 449 s 1; 1Sp2001 c 9 art 4 s 15-27; 2002 c 375 art 2 s 20-25; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 2 s 18-25; 2005 c 68 art 2 s 1; 2005 c 98 art 2 s 6; 1Sp2005 c 4 art 7 s 20-23; 2007 c 147 art 6 s 29-38; 2009 c 79 art 8 s 44; 2009 c 159 s 92-94; 1Sp2011 c 9 art 7 s 16; 2012 c 216 art 11 s 16,17; 2013 c 108 art 2 s 24,44; art 15 s 3,4; 2014 c 262 art 4 s 1,2*

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;

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(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

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(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 service with the 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

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(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 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 upon determining 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

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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.

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(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: *1986 c 444; 1999 c 245 art 4 s 60*

256B.0915 MEDICAID WAIVER FOR ELDERLY SERVICES.

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

Subd. 1a. **Elderly waiver case management services.** (a) Except as provided to individuals under prepaid medical assistance programs as described in paragraph (h), case management services under the home and community-based services waiver for elderly individuals are available from providers meeting qualification requirements and the standards specified in subdivision 1b. Eligible recipients may choose any qualified provider of case management services.

(b) Case management services assist individuals who receive waiver services in gaining access to needed waiver and other state plan services and assist individuals in appeals under section 256.045, as well as needed medical, social, educational, and other services regardless of the funding source for the services to which access is gained. Case managers shall collaborate with consumers, families, legal representatives, and relevant medical experts and service providers in the development and periodic review of the coordinated service and support plan.

(c) A case aide shall provide assistance to the case manager in carrying out administrative activities of the case management function. The case aide may not assume responsibilities that require professional judgment including assessments, reassessments, and care plan development. The case manager is responsible for providing oversight of the case aide.

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(d) Case managers shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care. Case managers shall initiate the process of reassessment of the individual's coordinated service and support plan and review the plan at intervals specified in the federally approved waiver plan.

(e) The county of service or tribe must provide access to and arrange for case management services. County of service has the meaning given it in Minnesota Rules, part 9505.0015, subpart 11.

(f) Except as described in paragraph (h), case management services must be provided by a public or private agency that is enrolled as a medical assistance provider determined by the commissioner to meet all of the requirements in subdivision 1b. Case management services must not be provided to a recipient by a private agency that has a financial interest in the provision of any other services included in the recipient's coordinated service and support plan. For purposes of this section, "private agency" means any agency that is not identified as a lead agency under section 256B.0911, subdivision 1a, paragraph (e).

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

(1) development of the coordinated service and support plan under subdivision 6;

(2) informing the individual or the individual's legal guardian or conservator of service options, and options for case management services and providers;

(3) consulting with relevant medical experts or service providers;

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

(5) assisting the person to access services;

(6) coordination of services; and

(7) evaluation and monitoring of the services identified in the plan, which must incorporate at least one annual face-to-face visit by the case manager with each person.

(h) Notwithstanding any requirements in this section, for individuals enrolled in prepaid medical assistance programs under section 256B.69, subdivisions 6b and 23, the health plan shall provide or arrange to provide elderly waiver case management services in paragraph (g), in accordance with contract requirements established by the commissioner.

Subd. 1b. **Provider qualifications and standards.** (a) The commissioner must enroll qualified providers of case management services under the home and community-based waiver for the elderly under section 1915(c) of the Social Security Act. The enrollment process shall ensure the provider's ability to meet the qualification requirements and standards in this subdivision and other federal and state requirements of this service. A case management provider is an enrolled medical assistance provider who is determined by the commissioner to have all of the following characteristics:

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

(2) administrative capacity and experience in serving the target population for whom it will provide services and in ensuring quality of services under state and federal requirements;

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

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

(5) the lead agency may allow a case manager employed by the lead agency to delegate certain aspects of the case management activity to another individual employed by the lead agency provided there is oversight of the individual by the case manager. The case manager may not delegate those aspects which require professional judgment including assessments, reassessments, and coordinated service and support plan development. Lead agencies include counties, health plans, and federally recognized tribes who authorize services under this section.

(b) A health plan shall provide or arrange to provide elderly waiver case management services in subdivision 1a, paragraph (g), in accordance with contract requirements established by the commissioner related to provider standards and qualifications.

Subd. 1c. [Repealed by amendment, 2007 c 147 art 7 s 15]

Subd. 1d. **Posteligibility treatment of income and resources for elderly waiver.** Notwithstanding the provisions of section 256B.056, the commissioner shall make the following amendment to the medical assistance elderly waiver program effective July 1, 1999, or upon federal approval, whichever is later.

A recipient's maintenance needs will be an amount equal to the Minnesota supplemental aid equivalent rate as defined in section 256I.03, subdivision 5, plus the medical assistance personal needs allowance as defined in section 256B.35, subdivision 1, paragraph (a), when applying posteligibility treatment of income rules to the gross income of elderly waiver recipients, except for individuals whose income is in excess of the special income standard according to Code of Federal Regulations, title 42, section 435.236. Recipient maintenance needs shall be adjusted under this provision each July 1.

Subd. 2. **Spousal impoverishment policies.** The commissioner shall apply the spousal impoverishment criteria as authorized under United States Code, title 42, section 1396r-5, and as implemented in sections 256B.0575, 256B.058, and 256B.059, except that individuals with income at or below the special income standard according to Code of Federal Regulations, title 42, section 435.236, receive the maintenance needs amount in subdivision 1d.

Subd. 3. **Limits of cases.** The number of medical assistance waiver recipients that a lead agency may serve must be allocated according to the number of medical assistance waiver cases open on July 1 of each fiscal year. Additional recipients may be served with the approval of the commissioner.

Subd. 3a. [Repealed, 1Sp2001 c 9 art 3 s 76; art 4 s 34]

Subd. 3a. **Elderly waiver cost limits.** (a) The monthly limit for the cost of waivered services to an individual elderly waiver client except for individuals described in paragraphs (b) and (d) shall be the weighted average monthly nursing facility rate of the case mix resident class to which the elderly waiver client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the recipient's maintenance needs allowance as described in subdivision 1d, paragraph (a), until the first day of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented. Effective on the first day of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented and the first day of each

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subsequent state fiscal year, the monthly limit for the cost of waivered services to an individual elderly waiver client shall be the rate of the case mix resident class to which the waiver client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, in effect on the last day of the previous state fiscal year, adjusted by any legislatively adopted home and community-based services percentage rate adjustment.

(b) The monthly limit for the cost of waivered services to an individual elderly waiver client assigned to a case mix classification A under paragraph (a) with:

(1) no dependencies in activities of daily living; or

(2) up to two dependencies in bathing, dressing, grooming, walking, and eating when the dependency score in eating is three or greater as determined by an assessment performed under section 256B.0911 shall be $1,750 per month effective on July 1, 2011, for all new participants enrolled in the program on or after July 1, 2011. This monthly limit shall be applied to all other participants who meet this criteria at reassessment. This monthly limit shall be increased annually as described in paragraph (a).

(c) If extended medical supplies and equipment or environmental modifications are or will be purchased for an elderly waiver client, the costs may be prorated for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's waivered services exceeds the monthly limit established in paragraph (a) or (b), the annual cost of all waivered services shall be determined. In this event, the annual cost of all waivered services shall not exceed 12 times the monthly limit of waivered services as described in paragraph (a) or (b).

(d) Effective July 1, 2013, the monthly cost limit of waiver services, including any necessary home care services described in section 256B.0651, subdivision 2, for individuals who meet the criteria as ventilator-dependent given in section 256B.0651, subdivision 1, paragraph (g), shall be the average of the monthly medical assistance amount established for home care services as described in section 256B.0652, subdivision 7, and the annual average contracted amount established by the commissioner for nursing facility services for ventilator-dependent individuals. This monthly limit shall be increased annually as described in paragraph (a).

Subd. 3b. [Repealed, 1Sp2001 c 9 art 3 s 76; art 4 s 34]

Subd. 3b. **Cost limits for elderly waiver applicants who reside in a nursing facility.** (a) For a person who is a nursing facility resident at the time of requesting a determination of eligibility for elderly waivered services, a monthly conversion budget limit for the cost of elderly waivered services may be requested. The monthly conversion budget limit for the cost of elderly waiver services shall be the resident class assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, for that resident in the nursing facility where the resident currently resides until July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented. Effective on July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented, the monthly conversion budget limit for the cost of elderly waiver services shall be based on the per diem nursing facility rate as determined by the resident assessment system as described in section 256B.438 for residents in the nursing facility where the elderly waiver applicant currently resides. The monthly conversion budget limit shall be calculated by multiplying the per diem by 365, divided by 12, and reduced by the recipient's maintenance needs allowance as described in subdivision 1d. The initially approved monthly conversion budget limit shall be adjusted annually as described in subdivision 3a, paragraph (a). The limit under this subdivision only applies to persons discharged from a nursing facility after a minimum 30-day stay and found eligible for waivered services on or after July 1, 1997.

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For conversions from the nursing home to the elderly waiver with consumer directed community support services, the nursing facility per diem used to calculate the monthly conversion budget limit must be reduced by a percentage equal to the percentage difference between the consumer directed services budget limit that would be assigned according to the federally approved waiver plan and the corresponding community case mix cap, but not to exceed 50 percent.

(b) The following costs must be included in determining the total monthly costs for the waiver client:

(1) cost of all waivered services, including specialized supplies and equipment and environmental accessibility adaptations; and

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

Subd. 3c. [Repealed, 1Sp2001 c 9 art 3 s 76; art 4 s 34]

Subd. 3c. **Service approval provisions.** Medical assistance funding for skilled nursing services, home care nursing, home health aide, and personal care services for waiver recipients must be approved by the case manager and included in the coordinated service and support plan.

Subd. 3d. **Adult foster care rate.** The adult foster care rate shall not include room and board. The elderly waiver payment for the foster care service in combination with the payment for all other elderly waiver services, including case management, must not exceed the limit specified in subdivision 3a, paragraph (a).

Subd. 3e. **Customized living service rate.** (a) Payment for customized living services shall be a monthly rate authorized by the lead agency within the parameters established by the commissioner. The payment agreement must delineate the amount of each component service included in the recipient's customized living service plan. The lead agency, with input from the provider of customized living services, shall ensure that there is a documented need within the parameters established by the commissioner for all component customized living services authorized.

(b) The payment rate must be based on the amount of component services to be provided utilizing component rates established by the commissioner. Counties and tribes shall use tools issued by the commissioner to develop and document customized living service plans and rates.

(c) Component service rates must not exceed payment rates for comparable elderly waiver or medical assistance services and must reflect economies of scale. Customized living services must not include rent or raw food costs.

(d) With the exception of individuals described in subdivision 3a, paragraph (b), the individualized monthly authorized payment for the customized living service plan shall not exceed 50 percent of the greater of either the statewide or any of the geographic groups' weighted average monthly nursing facility rate of the case mix resident class to which the elderly waiver eligible client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the maintenance needs allowance as described in subdivision 1d, paragraph (a), until the July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented. Effective on July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented and July 1 of each subsequent state fiscal year, the individualized monthly authorized payment for the services described in this clause shall not exceed the limit which was in effect on June 30 of the previous state fiscal year updated annually based on legislatively adopted changes to all service rate maximums for home and community-based service providers.

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(e) Effective July 1, 2011, the individualized monthly payment for the customized living service plan for individuals described in subdivision 3a, paragraph (b), must be the monthly authorized payment limit for customized living for individuals classified as case mix A, reduced by 25 percent. This rate limit must be applied to all new participants enrolled in the program on or after July 1, 2011, who meet the criteria described in subdivision 3a, paragraph (b). This monthly limit also applies to all other participants who meet the criteria described in subdivision 3a, paragraph (b), at reassessment.

(f) Customized living services are delivered by a provider licensed by the Department of Health as a class A or class F home care provider and provided in a building that is registered as a housing with services establishment under chapter 144D. Licensed home care providers are subject to section 256B.0651, subdivision 14.

(g) A provider may not bill or otherwise charge an elderly waiver participant or their family for additional units of any allowable component service beyond those available under the service rate limits described in paragraph (d), nor for additional units of any allowable component service beyond those approved in the service plan by the lead agency.

Subd. 3f. **Payments for services; expenditure forecasts.** (a) Lead agencies shall authorize payments for services in accordance with the payment rates and limits published annually by the commissioner.

(b) Reimbursement for the medical assistance recipients under the approved waiver shall be made from the medical assistance account through the invoice processing procedures of the department's Medicaid Management Information System (MMIS), only with the approval of the client's case manager. The budget for the state share of the Medicaid expenditures shall be forecasted with the medical assistance budget, and shall be consistent with the approved waiver.

Subd. 3g. **Service rate limits; state assumption of costs.** (a) To improve access to community services and eliminate payment disparities between the alternative care program and the elderly waiver, the commissioner shall establish statewide service rate limits and eliminate lead agency-specific service rate limits.

(b) Effective July 1, 2001, for statewide service rate limits, except those described or defined in subdivisions 3d, 3e, and 3h, the statewide service rate limit for each service shall be the greater of the alternative care statewide rate or the elderly waiver statewide rate.

Subd. 3h. **Service rate limits; 24-hour customized living services.** (a) The payment rate for 24-hour customized living services is a monthly rate authorized by the lead agency within the parameters established by the commissioner of human services. The payment agreement must delineate the amount of each component service included in each recipient's customized living service plan. The lead agency, with input from the provider of customized living services, shall ensure that there is a documented need within the parameters established by the commissioner for all component customized living services authorized. The lead agency shall not authorize 24-hour customized living services unless there is a documented need for 24-hour supervision.

(b) For purposes of this section, "24-hour supervision" means that the recipient requires assistance due to needs related to one or more of the following:

(1) intermittent assistance with toileting, positioning, or transferring;

(2) cognitive or behavioral issues;

(3) a medical condition that requires clinical monitoring; or

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(4) for all new participants enrolled in the program on or after July 1, 2011, and all other participants at their first reassessment after July 1, 2011, dependency in at least three of the following activities of daily living as determined by assessment under section 256B.0911: bathing; dressing; grooming; walking; or eating when the dependency score in eating is three or greater; and needs medication management and at least 50 hours of service per month. The lead agency shall ensure that the frequency and mode of supervision of the recipient and the qualifications of staff providing supervision are described and meet the needs of the recipient.

(c) The payment rate for 24-hour customized living services must be based on the amount of component services to be provided utilizing component rates established by the commissioner. Counties and tribes will use tools issued by the commissioner to develop and document customized living plans and authorize rates.

(d) Component service rates must not exceed payment rates for comparable elderly waiver or medical assistance services and must reflect economies of scale.

(e) The individually authorized 24-hour customized living payments, in combination with the payment for other elderly waiver services, including case management, must not exceed the recipient's community budget cap specified in subdivision 3a. Customized living services must not include rent or raw food costs.

(f) The individually authorized 24-hour customized living payment rates shall not exceed the 95 percentile of statewide monthly authorizations for 24-hour customized living services in effect and in the Medicaid management information systems on March 31, 2009, for each case mix resident class under Minnesota Rules, parts 9549.0050 to 9549.0059, to which elderly waiver service clients are assigned. When there are fewer than 50 authorizations in effect in the case mix resident class, the commissioner shall multiply the calculated service payment rate maximum for the A classification by the standard weight for that classification under Minnesota Rules, parts 9549.0050 to 9549.0059, to determine the applicable payment rate maximum. Service payment rate maximums shall be updated annually based on legislatively adopted changes to all service rates for home and community-based service providers.

(g) Notwithstanding the requirements of paragraphs (d) and (f), the commissioner may establish alternative payment rate systems for 24-hour customized living services in housing with services establishments which are freestanding buildings with a capacity of 16 or fewer, by applying a single hourly rate for covered component services provided in either:

(1) licensed corporate adult foster homes; or

(2) specialized dementia care units which meet the requirements of section 144D.065 and in which:

(i) each resident is offered the option of having their own apartment; or

(ii) the units are licensed as board and lodge establishments with maximum capacity of eight residents, and which meet the requirements of Minnesota Rules, part 9555.6205, subparts 1, 2, 3, and 4, item A.

(h) Twenty-four-hour customized living services are delivered by a provider licensed by the Department of Health as a class A or class F home care provider and provided in a building that is registered as a housing with services establishment under chapter 144D. Licensed home care providers are subject to section 256B.0651, subdivision 14.

(i) A provider may not bill or otherwise charge an elderly waiver participant or their family for additional units of any allowable component service beyond those available under the service rate limits described in

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paragraph (e), nor for additional units of any allowable component service beyond those approved in the service plan by the lead agency.

Subd. 3i. **Rate reduction for customized living and 24-hour customized living services.** (a) Effective July 1, 2010, the commissioner shall reduce service component rates and service rate limits for customized living services and 24-hour customized living services, from the rates in effect on June 30, 2010, by five percent.

(b) To implement the rate reductions in this subdivision, capitation rates paid by the commissioner to managed care organizations under section 256B.69 shall reflect a ten percent reduction for the specified services for the period January 1, 2011, to June 30, 2011, and a five percent reduction for those services on and after July 1, 2011.

Subd. 3j. **Individual community living support.** Upon federal approval, there is established a new service called individual community living support (ICLS) that is available on the elderly waiver. ICLS providers may not be the landlord of recipients, nor have any interest in the recipient's housing. ICLS must be delivered in a single-family home or apartment where the service recipient or their family owns or rents, as demonstrated by a lease agreement, and maintains control over the individual unit. Case managers or care coordinators must develop individual ICLS plans in consultation with the client using a tool developed by the commissioner. The commissioner shall establish payment rates and mechanisms to align payments with the type and amount of service provided, assure statewide uniformity for payment rates, and assure cost-effectiveness. Licensing standards for ICLS shall be reviewed jointly by the Departments of Health and Human Services to avoid conflict with provider regulatory standards pursuant to section 144A.43 and chapter 245D.

Subd. 4. **Termination notice.** The case manager must give the individual a ten-day written notice of any denial, reduction, or termination of waivered services.

Subd. 5. **Assessments and reassessments for waiver clients.** (a) Each client shall receive an initial assessment of strengths, informal supports, and need for services in accordance with section 256B.0911, subdivisions 3, 3a, and 3b. A reassessment of a client served under the elderly waiver must be conducted at least every 12 months and at other times when the case manager determines that there has been significant change in the client's functioning. This may include instances where the client is discharged from the hospital. There must be a determination that the client requires nursing facility level of care as defined in section 256B.0911, subdivision 4e, at initial and subsequent assessments to initiate and maintain participation in the waiver program.

(b) Regardless of other assessments identified in section 144.0724, subdivision 4, as appropriate to determine nursing facility level of care for purposes of medical assistance payment for nursing facility services, only face-to-face assessments conducted according to section 256B.0911, subdivisions 3a and 3b, that result in a nursing facility level of care determination will be accepted for purposes of initial and ongoing access to waiver service payment.

Subd. 6. **Implementation of coordinated service and support plan.** (a) Each elderly waiver client shall be provided a copy of a written coordinated service and support plan which:

(1) is developed and signed by the recipient within ten working days after the case manager receives the assessment information and written community support plan as described in section 256B.0911, subdivision 3a, from the certified assessor;

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(2) includes the person's need for service and identification of service needs that will be or that are met by the person's relatives, friends, and others, as well as community services used by the general public;

(3) reasonably ensures the health and welfare of the recipient;

(4) identifies the person's preferences for services as stated by the person or the person's legal guardian or conservator;

(5) reflects the person's informed choice between institutional and community-based services, as well as choice of services, supports, and providers, including available case manager providers;

(6) identifies long-range and short-range goals for the person;

(7) identifies specific services and the amount, frequency, duration, and cost of the services to be provided to the person based on assessed needs, preferences, and available resources;

(8) includes information about the right to appeal decisions under section 256.045; and

(9) includes the authorized annual and estimated monthly amounts for the services.

(b) In developing the coordinated service and support plan, the case manager should also include the use of volunteers, religious organizations, social clubs, and civic and service organizations to support the individual in the community. The lead agency must be held harmless for damages or injuries sustained through the use of volunteers and agencies under this paragraph, including workers' compensation liability.

Subd. 7. **Prepaid elderly waiver services.** An individual for whom a prepaid health plan is liable for nursing home services or elderly waiver services according to section 256B.69, subdivision 6a, is not eligible to also receive county-administered elderly waiver services.

Subd. 8. **Services and supports.** (a) Services and supports shall meet the requirements set out in United States Code, title 42, section 1396n.

(b) Services and supports shall promote consumer choice and be arranged and provided consistent with individualized, written care plans.

(c) The state of Minnesota, county, managed care organization, or tribal government under contract to administer the elderly waiver shall not be liable for damages, injuries, or liabilities sustained through the purchase of direct supports or goods by the person, the person's family, or the authorized representatives with funds received through consumer-directed community support services under the federally approved waiver plan. Liabilities include, but are not limited to, workers' compensation liability, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA).

Subd. 9. **Tribal management of elderly waiver.** Notwithstanding contrary provisions of this section, or those in other state laws or rules, the commissioner may develop a model for tribal management of the elderly waiver program and implement this model through a contract between the state and any of the state's federally recognized tribal governments. The model shall include the provision of tribal waiver case management, assessment for personal care assistance, and administrative requirements otherwise carried out by lead agencies but shall not include tribal financial eligibility determination for medical assistance.

Subd. 10. **Waiver payment rates; managed care organizations.** The commissioner shall adjust the elderly waiver capitation payment rates for managed care organizations paid under section 256B.69, subdivisions 6band 23, to reflect the maximum service rate limits for customized living services and 24-hour

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customized living services under subdivisions 3e and 3h. Medical assistance rates paid to customized living providers by managed care organizations under this section shall not exceed the maximum service rate limits and component rates as determined by the commissioner under subdivisions 3e and 3h.

History: *1991 c 292 art 7 s 16; 1992 c 513 art 7 s 62-64; 1Sp1993 c 1 art 5 s 68-72; 1Sp1993 c 6 s 13; 1995 c 207 art 6 s 70-74; 1995 c 263 s 9; 1996 c 451 art 2 s 26-28; art 5 s 23,24; 1997 c 113 s 18; 1997 c 203 art 4 s 40-43; 1998 c 407 art 4 s 37,38; 1Sp2001 c 9 art 4 s 28-30; 2002 c 277 s 16,17; 2002 c 375 art 2 s 26-30; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 2 s 26; art 3 s 30; 2004 c 288 art 5 s 5,6; 2005 c 68 art 2 s 2-4; 2007 c 147 art 7 s 15; 2008 c 277 art 1 s 36,37; 2009 c 79 art 8 s 45-49; 2009 c 159 s 95; 1Sp2010 c 1 art 17 s 11; 1Sp2011 c 9 art 7 s 17-22; 2012 c 216 art 11 s 18-22; 2012 c 247 art 4 s 24,25; 2012 c 253 art 3 s 2,3; 2013 c 108 art 2 s 25,44; art 7 s 6,7; art 15 s 3,4; 2014 c 262 art 4 s 3-6; 2014 c 291 art 9 s 5; 2014 c 312 art 27 s 77*

256B.0916 EXPANSION OF HOME AND COMMUNITY-BASED SERVICES.

Subdivision 1. [Repealed, 2002 c 220 art 14 s 20]

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 developmental disabilities 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; and

(2) statewide priorities identified in section 256B.092, subdivision 12.

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

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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. **Allocation of new diversions and priorities for reassignment of resources for developmental disabilities.** (a) The commissioner shall monitor county utilization of allocated resources and, as appropriate, reassign resources not utilized.

(b) Effective July 1, 2002, the commissioner shall authorize the spending of new diversion resources beginning January 1 of each year.

(c) Effective July 1, 2002, the commissioner shall manage the reassignment of waiver resources that occur from persons who have left the waiver in a manner that results in the cost reduction equivalent to delaying the reuse of those waiver resources by 180 days.

(d) Priority consideration for reassignment of resources shall be given to 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. [Repealed, 2014 c 262 art 4 s 9]

Subd. 6a. [Repealed, 2014 c 262 art 4 s 9]

Subd. 7. MS 2012 [Expired, 2012 c 216 art 9 s 23]

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 developmental disabilities, 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 the home and community-based waiver for persons with developmental disabilities or the consumer support grant program pursuant to section 256.476, shall not be considered to have a direct or indirect service provider interest under section 256B.092, subdivision 7, if a health and safety plan which

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meets the criteria established has been agreed upon and implemented. By August 1, 2001, the commissioner shall submit, for federal approval, amendments to allow legal representatives to provide support and receive reimbursement under the home and community-based waiver plan.

Subd. 10. **Transitional supports allowance.** A transitional supports allowance shall be available to all persons under a home and community-based waiver who are moving from a licensed setting to a community setting. "Transitional supports allowance" means a onetime payment of up to $3,000, to cover the costs, not covered by other sources, associated with moving from a licensed setting to a community setting. Covered costs include:

(1) lease or rent deposits;

(2) security deposits;

(3) utilities setup costs, including telephone;

(4) essential furnishings and supplies; and

(5) personal supports and transports needed to locate and transition to community settings.

Subd. 11. **Excess spending.** County and tribal agencies are responsible for spending in excess of the allocation made by the commissioner. In the event a county or tribal agency spends in excess of the allocation made by the commissioner for a given allocation period, they must submit a corrective action plan to the commissioner. The plan must state the actions the agency will take to correct their overspending for the year following the period when the overspending occurred. Failure to correct overspending shall result in recoupment of spending in excess of the allocation. Nothing in this subdivision shall be construed as reducing the county's responsibility to offer and make available feasible home and community-based options to eligible waiver recipients within the resources allocated to them for that purpose.

History: *1Sp1993 c 1 art 4 s 8; 1998 c 407 art 4 s 39; 1999 c 245 art 4 s 61; 2000 c 488 art 11 s 7; 1Sp2001 c 9 art 3 s 43-45; 2002 c 220 art 14 s 6; 2002 c 379 art 1 s 113; 2004 c 288 art 3 s 24; 2005 c 56 s 1; 1Sp2005 c 4 art 8 s 46; 2009 c 79 art 8 s 50; 2012 c 216 art 9 s 23; 2013 c 108 art 7 s 8*

256B.0917 HOME AND COMMUNITY-BASED SERVICES FOR OLDER ADULTS.

Subdivision 1. [Repealed, 2013 c 108 art 2 s 45]

Subd. 1a. **Home and community-based services for older adults.** (a) The purpose of projects selected by the commissioner of human services under this section is to make strategic changes in the long-term services and supports system for older adults including statewide capacity for local service development and technical assistance, and statewide availability of home and community-based services for older adult services, caregiver support and respite care services, and other supports in the state of Minnesota. These projects are intended to create incentives for new and expanded home and community-based services in Minnesota in order to:

(1) reach older adults early in the progression of their need for long-term services and supports, providing them with low-cost, high-impact services that will prevent or delay the use of more costly services;

(2) support older adults to live in the most integrated, least restrictive community setting;

(3) support the informal caregivers of older adults;

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(4) develop and implement strategies to integrate long-term services and supports with health care services, in order to improve the quality of care and enhance the quality of life of older adults and their informal caregivers;

(5) ensure cost-effective use of financial and human resources;

(6) build community-based approaches and community commitment to delivering long-term services and supports for older adults in their own homes;

(7) achieve a broad awareness and use of lower-cost in-home services as an alternative to nursing homes and other residential services;

(8) strengthen and develop additional home and community-based services and alternatives to nursing homes and other residential services; and

(9) strengthen programs that use volunteers.

(b) The services provided by these projects are available to older adults who are eligible for medical assistance and the elderly waiver under section 256B.0915, the alternative care program under section 256B.0913, or essential community supports grant under section 256B.0922, and to persons who have their own funds to pay for services.

Subd. 1b. **Definitions.** (a) For purposes of this section, the following terms have the meanings given.

(b) "Community" means a town; township; city; or targeted neighborhood within a city; or a consortium of towns, townships, cities, or specific neighborhoods within a city.

(c) "Core home and community-based services provider" means a Faith in Action, Living at Home Block Nurse, Congregational Nurse, or similar community-based program governed by a board, the majority of whose members reside within the program's service area, that organizes and uses volunteers and paid staff to deliver nonmedical services intended to assist older adults to identify and manage risks and to maintain their community living and integration in the community.

(d) "Eldercare development partnership" means a team of representatives of county social service and public health agencies, the area agency on aging, local nursing home providers, local home care providers, and other appropriate home and community-based providers in the area agency's planning and service area.

(e) "Long-term services and supports" means any service available under the elderly waiver program or alternative care grant programs, nursing facility services, transportation services, caregiver support and respite care services, and other home and community-based services identified as necessary either to maintain lifestyle choices for older adults or to support them to remain in their own home.

(f) "Older adult" refers to an individual who is 65 years of age or older.

Subd. 1c. **Eldercare development partnerships.** The commissioner of human services shall select and contract with eldercare development partnerships sufficient to provide statewide availability of service development and technical assistance using a request for proposals process. Eldercare development partnerships shall:

(1) develop a local long-term services and supports strategy consistent with state goals and objectives;

(2) identify and use existing local skills, knowledge, and relationships, and build on these assets;

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(3) coordinate planning for funds to provide services to older adults, including funds received under title III of the Older Americans Act, title XX of the Social Security Act, and the Local Public Health Act;

(4) target service development and technical assistance where nursing facility closures have occurred or are occurring or in areas where service needs have been identified through activities under section 144A.351;

(5) provide sufficient staff for development and technical support in its designated area; and

(6) designate a single public or nonprofit member of the eldercare development partnerships to apply grant funding and manage the project.

Subd. 2. [Repealed, 2013 c 108 art 2 s 45]

Subd. 3. [Repealed, 2013 c 108 art 2 s 45]

Subd. 4. [Repealed, 2013 c 108 art 2 s 45]

Subd. 5. [Repealed, 2013 c 108 art 2 s 45]

Subd. 6. **Caregiver support and respite care projects.** (a) The commissioner shall establish projects to expand the availability of caregiver support and respite care services for family and other caregivers. The commissioner shall use a request for proposals to select nonprofit entities to administer the projects. Projects shall:

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

(2) coordinate assignment of respite care services to caregivers of older adults;

(3) assure the health and safety of the older adults;

(4) identify at-risk caregivers;

(5) provide information, education, and training for caregivers in the designated community; and

(6) demonstrate the need in the proposed service area particularly where nursing facility closures have occurred or are occurring or areas with service needs identified by section 144A.351. Preference must be given for projects that reach underserved populations.

(b) Projects must clearly describe:

(1) how they will achieve their purpose;

(2) the process for recruiting, training, and retraining volunteers; and

(3) a plan to promote the project in the designated community, including outreach to persons needing the services.

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

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

(2) recruit and train volunteer providers;

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(3) provide information, training, and education to caregivers;

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

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

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

Subd. 7. [Repealed, 2013 c 108 art 2 s 45]

Subd. 7a. **Core home and community-based services.** The commissioner shall select and contract with core home and community-based services providers for projects to provide services and supports to older adults both with and without family and other informal caregivers using a request for proposals process. Projects must:

(1) have a credible, public, or private nonprofit sponsor providing ongoing financial support;

(2) have a specific, clearly defined geographic service area;

(3) use a practice framework designed to identify high-risk older adults and help them take action to better manage their chronic conditions and maintain their community living;

(4) have a team approach to coordination and care, ensuring that the older adult participants, their families, and the formal and informal providers are all part of planning and providing services;

(5) provide information, support services, homemaking services, counseling, and training for the older adults and family caregivers;

(6) encourage service area or neighborhood residents and local organizations to collaborate in meeting the needs of older adults in their geographic service areas;

(7) recruit, train, and direct the use of volunteers to provide informal services and other appropriate support to older adults and their caregivers; and

(8) provide coordination and management of formal and informal services to older adults and their families using less expensive alternatives.

Subd. 8. [Repealed, 2013 c 108 art 2 s 45]

Subd. 9. [Repealed, 2013 c 108 art 2 s 45]

Subd. 10. [Repealed, 2013 c 108 art 2 s 45]

Subd. 11. [Repealed, 2013 c 108 art 2 s 45]

Subd. 12. [Repealed, 2013 c 108 art 2 s 45]

Subd. 13. **Community service grants.** The commissioner shall award contracts for grants to public and private nonprofit agencies to establish services that strengthen a community's ability to provide a system of home and community-based services for elderly persons. The commissioner shall use a request for proposal process. The commissioner shall give preference when awarding grants under this section to areas where nursing facility closures have occurred or are occurring or to areas with service needs identified under section 144A.351.

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Subd. 14. [Repealed, 2013 c 108 art 7 s 64]

History: *1991 c 292 art 7 s 17; 1992 c 513 art 7 s 65-72; 1Sp1993 c 1 art 5 s 73-79; 1994 c 625 art 8 s 63; 1997 c 203 art 4 s 44,45; 1999 c 245 art 4 s 62; 2000 c 488 art 9 s 36; 2001 c 161 s 46,47; 1Sp2001 c 9 art 4 s 31,32; 2002 c 379 art 1 s 113; 2005 c 10 art 1 s 51,52; 2005 c 98 art 3 s 24; 2006 c 212 art 3 s 19; 2009 c 79 art 8 s 51; 1Sp2010 c 1 art 17 s 14; 1Sp2011 c 9 art 7 s 48; 2013 c 108 art 2 s 26-31,44; art 15 s 3,4; 2014 c 275 art 1 s 60*

256B.0918 EMPLOYEE SCHOLARSHIP COSTS.

Subdivision 1. **Program criteria.** Beginning on or after October 1, 2005, within the limits of appropriations specifically available for this purpose, the commissioner shall provide funding to qualified provider applicants for employee scholarships for education in nursing and other health care fields. Employee scholarships must be for a course of study that is expected to lead to career advancement with the provider or in the field of long-term care, including home care or care of persons with disabilities, or nursing. Providers that secure this funding must use it to award scholarships to employees who work an average of at least 20 hours per week for the provider. Executive management staff without direct care duties, registered nurses, and therapists are not eligible to receive scholarships under this section.

Subd. 2. **Participating providers.** The commissioner shall publish a request for proposals in the State Register by August 15, 2005, specifying provider eligibility requirements, provider selection criteria, program specifics, funding mechanism, and methods of evaluation. The commissioner may publish additional requests for proposals in subsequent years. Providers who provide services funded through the following programs are eligible to apply to participate in the scholarship program: home and community-based waivered services for persons with developmental disabilities under section 256B.501; home and community-based waivered 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; 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; home care nursing services under section 256B.0625, subdivision 7; day training and habilitation services for adults with developmental disabilities under sections 252.41 to 252.46; and intermediate care facilities for persons with developmental disabilities under section 256B.5012.

Subd. 3. **Provider selection criteria.** To be considered for scholarship funding, the provider shall submit a completed application within the time frame specified by the commissioner. In awarding funding, the commissioner shall consider the following:

(1) the size of the provider as measured in annual billing to the medical assistance program. To be eligible, a provider must receive at least $300,000 annually in medical assistance payments;

(2) the percentage of employees meeting the scholarship program recipient requirements;

(3) staff retention rates for paraprofessionals; and

(4) other criteria determined by the commissioner.

Subd. 4. **Funding specifics.** Within the limits of appropriations specifically available for this purpose, for the rate period beginning on or after October 1, 2005, to September 30, 2007, the commissioner shall provide to each provider listed in subdivision 2 and awarded funds under subdivision 3 a medical assistance rate increase to fund scholarships up to three-tenths percent of the medical assistance reimbursement rate.

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The commissioner shall require providers to repay any portion of funds awarded under subdivision 3 that is not used to fund scholarships. If applications exceed available funding, funding shall be targeted to providers that employ a higher percentage of paraprofessional staff or have lower rates of turnover of paraprofessional staff. During the subsequent years of the program, the rate adjustment may be recalculated, at the discretion of the commissioner. In making a recalculation the commissioner may consider the provider's success at granting scholarships based on the amount spent during the previous year and the availability of appropriations to continue the program.

Subd. 5. **Reporting requirements.** Participating providers shall report to the commissioner on a schedule determined by the commissioner and on a form supplied by the commissioner for a scholarship rate for rate periods beginning October 1, 2007. The report shall include the amount spent during the reporting period on eligible scholarships, and, for each scholarship recipient, the name of the recipient, the amount awarded, the educational institution attended, the nature of the educational program, the expected or actual program completion date, and a determination of the amount spent as a percentage of the provider's reimbursement. The commissioner shall require providers to repay all of the funds awarded under subdivision 3 if the report required in this subdivision is not filled according to the schedule determined by the commissioner.

Subd. 6. **Evaluation.** The commissioner shall report to the legislature annually, beginning March 15, 2007, on the use of these funds.

History: *2005 c 56 s 1; 1Sp2005 c 4 art 8 s 47; 2006 c 282 art 20 s 17-19; 2012 c 216 art 14 s 2; 2014 c 275 art 1 s 61; 2014 c 291 art 9 s 5*

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

Subdivision 1. **Adult foster care licensure capacity.** Notwithstanding contrary provisions of the Human Services Licensing Act and rules adopted under it, an adult foster care license holder may care for five adults age 60 years or older who do not have serious and persistent mental illness or a developmental disability.

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

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

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Subd. 4. [Repealed, 2010 c 329 art 1 s 24; 2010 c 352 art 2 s 16]

History: *1986 c 444; 1991 c 292 art 7 s 18; 1992 c 513 art 7 s 73; 2007 c 112 s 49; 2007 c 147 art 6 s 39*

256B.092 SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES.

Subdivision 1. **County of financial responsibility; duties.** Before any services shall be rendered to persons with developmental disabilities who are in need of social service and medical assistance, the county of financial responsibility shall conduct or arrange for a diagnostic evaluation in order to determine whether the person has or may have a developmental disability or has or may have a related condition. If the county of financial responsibility determines that the person has a developmental disability, the county shall inform the person of case management services available under this section. Except as provided in subdivision 1g or 4b, if a person is diagnosed as having a developmental disability, the county of financial responsibility shall conduct or arrange for a needs assessment by a certified assessor, and develop a community support plan according to section 256B.0911, and authorize services identified in the person's coordinated service and support plan developed according to subdivision 1b. Diagnostic information, obtained by other providers or agencies, may be used by the county agency in determining eligibility for case management. Nothing in this section shall be construed as requiring: (1) assessment in areas agreed to as unnecessary by a certified assessor and the person, or the person's legal guardian or conservator, or the parent if the person is a minor, or (2) assessments in areas where there has been a functional assessment completed in the previous 12 months for which the certified assessor and the person or person's guardian or conservator, or the parent if the person is a minor, agree that further assessment is not necessary. For persons under state guardianship, the certified assessor shall seek authorization from the public guardianship office for waiving any assessment requirements. Assessments related to health, safety, and protection of the person for the purpose of identifying service type, amount, and frequency or assessments required to authorize services may not be waived. To the extent possible, for wards of the commissioner the county shall consider the opinions of the parent of the person with a developmental disability when developing the person's community support plan and coordinated service and support plan.

Subd. 1a. **Case management services.** (a) Each recipient of a home and community-based waiver shall be provided case management services by qualified vendors as described in the federally approved waiver application.

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

(1) development of the coordinated service and support plan under subdivision 1b;

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

(3) consulting with relevant medical experts or service providers;

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

(5) assisting the person to access services and assisting in appeals under section 256.045;

(6) coordination of services, if coordination is not provided by another service provider;

(7) evaluation and monitoring of the services identified in the coordinated service and support plan, which must incorporate at least one annual face-to-face visit by the case manager with each person; and

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(8) reviewing coordinated service and support plans and providing the lead agency with recommendations for service authorization based upon the individual's needs identified in the coordinated service and support plan.

(c) Case management service activities that are provided to the person with a developmental disability shall be provided directly by county agencies or under contract. Case management services must be provided by a public or private agency that is enrolled as a medical assistance provider determined by the commissioner to meet all of the requirements in the approved federal waiver plans. Case management services must not be provided to a recipient by a private agency that has a financial interest in the provision of any other services included in the recipient's coordinated service and support plan. For purposes of this section, "private agency" means any agency that is not identified as a lead agency under section 256B.0911, subdivision 1a, paragraph (e).

(d) Case managers are responsible for service provisions listed in paragraphs (a) and (b). Case managers shall collaborate with consumers, families, legal representatives, and relevant medical experts and service providers in the development and annual review of the coordinated service and support plan and habilitation plan.

(e) For persons who need a positive support transition plan as required in chapter 245D, the case manager shall participate in the development and ongoing evaluation of the plan with the expanded support team. At least quarterly, the case manager, in consultation with the expanded support team, shall evaluate the effectiveness of the plan based on progress evaluation data submitted by the licensed provider to the case manager. The evaluation must identify whether the plan has been developed and implemented in a manner to achieve the following within the required timelines:

(1) phasing out the use of prohibited procedures;

(2) acquisition of skills needed to eliminate the prohibited procedures within the plan's timeline; and

(3) accomplishment of identified outcomes.

If adequate progress is not being made, the case manager shall consult with the person's expanded support team to identify needed modifications and whether additional professional support is required to provide consultation.

(f) The Department of Human Services shall offer ongoing education in case management to case managers. Case managers shall receive no less than ten hours of case management education and disability-related training each year.

Subd. 1b. **Coordinated service and support plan.** (a) Each recipient of home and community-based waivered services shall be provided a copy of the written coordinated service and support plan which:

(1) is developed and signed by the recipient within ten working days after the case manager receives the assessment information and written community support plan as described in section 256B.0911, subdivision 3a, from the certified assessor;

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

(3) reasonably ensures the health and welfare of the recipient;

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(4) identifies the person's preferences for services as stated by the person, the person's legal guardian or conservator, or the parent if the person is a minor, including the person's choices made on self-directed options and on services and supports to achieve employment goals;

(5) provides for an informed choice, as defined in section 256B.77, subdivision 2, paragraph (o), of service and support providers, and identifies all available options for case management services and providers;

(6) identifies long-range and short-range goals for the person;

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

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

(9) identifies provider responsibilities to implement and make recommendations for modification to the coordinated service and support plan;

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

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

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

(13) includes the authorized annual and monthly amounts for the services.

(b) In developing the coordinated service and support plan, the case manager is encouraged to include the use of volunteers, religious organizations, social clubs, and civic and service organizations to support the individual in the community. The lead agency must be held harmless for damages or injuries sustained through the use of volunteers and agencies under this paragraph, including workers' compensation liability.

(c) Approved, written, and signed changes to a consumer's services that meet the criteria in this subdivision shall be an addendum to that consumer's individual service plan.

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

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

Subd. 1e. [Renumbered subd 1f]

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

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

(2) are designed to achieve the goals of the coordinated service and support plan;

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(3) are consistent with other aspects of the coordinated service and support plan;

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

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

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

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

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

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

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

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

Subd. 1f. **County waiting list.** The county agency shall maintain a waiting list of persons with developmental disabilities specifying the services needed but not provided. This waiting list shall be used by county agencies to assist them in developing needed services or amending their children and community service agreements.

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

(1) persons whose families are requesting respite care for their family member who resides with them, or whose families are requesting a family support grant and are not requesting purchase or arrangement of habilitative services; and

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

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

(1) provide consultation on the case management process;

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

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

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

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

Subd. 2a. **Medical assistance for case management activities under the state plan Medicaid option.** Upon receipt of federal approval, the commissioner shall make payments to approved vendors of case management services participating in the medical assistance program to reimburse costs for providing case management service activities to medical assistance eligible persons with developmental disabilities, in accordance with the state Medicaid plan and federal requirements and limitations.

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

Subd. 4. **Home and community-based services for developmental disabilities.** (a) The commissioner shall make payments to approved vendors participating in the medical assistance program to pay costs of providing home and community-based services, including case management service activities provided as an approved home and community-based service, to medical assistance eligible persons with developmental disabilities who have been screened under subdivision 7 and according to federal requirements. Federal requirements include those services and limitations included in the federally approved application for home and community-based services for persons with developmental disabilities and subsequent amendments.

(b) Effective July 1, 1995, contingent upon federal approval and state appropriations made available for this purpose, and in conjunction with Laws 1995, chapter 207, article 8, section 40, the commissioner of human services shall allocate resources to county agencies for home and community-based waivered services for persons with developmental disabilities authorized but not receiving those services as of June 30, 1995, based upon the average resource need of persons with similar functional characteristics. To ensure service continuity for service recipients receiving home and community-based waivered services for persons with developmental disabilities prior to July 1, 1995, the commissioner shall make available to the county of financial responsibility home and community-based waivered services resources based upon fiscal year 1995 authorized levels.

(c) Home and community-based resources for all recipients shall be managed by the county of financial responsibility within an allowable reimbursement average established for each county. Payments for home and community-based services provided to individual recipients shall not exceed amounts authorized by the county of financial responsibility. For specifically identified former residents of nursing facilities, the commissioner shall be responsible for authorizing payments and payment limits under the appropriate home and community-based service program. Payment is available under this subdivision only for persons who, if not provided these services, would require the level of care provided in an intermediate care facility for persons with developmental disabilities.

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

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

Subd. 4c. **Living arrangements based on a 24-hour plan of care.** (a) Notwithstanding the requirements for licensure under Minnesota Rules, part 9525.1860, subpart 6, item D, and upon federal approval of an amendment to the home and community-based services waiver for persons with developmental disabilities, a person receiving home and community-based services may choose to live in their own home without requiring that the living arrangement be licensed under Minnesota Rules, parts 9555.5050 to 9555.6265, provided the following conditions are met:

(1) the person receiving home and community-based services has chosen to live in their own home;

(2) home and community-based services are provided by a qualified vendor who meets the provider standards as approved in the Minnesota home and community-based services waiver plan for persons with developmental disabilities;

(3) the person, or their legal representative, individually or with others has purchased or rents the home and the person's service provider has no financial interest in the home; and

(4) the service planning team, as defined in Minnesota Rules, part 9525.0004, subpart 24, has determined that the planned services, the 24-hour plan of care, and the housing arrangement are appropriate to address the health, safety, and welfare of the person.

(b) The county agency may require safety inspections of the selected housing as part of their determination of the adequacy of the living arrangement.

Subd. 4d. **Medicaid reimbursement; licensed provider; related individuals.** Medicaid reimbursement for the provision of supported living services to a related individual is allowed when the conditions specified in section 245A.03, subdivision 9, are met.

Subd. 5. **Federal waivers.** (a) The commissioner shall apply for any federal waivers necessary to secure, to the extent allowed by law, federal financial participation under United States Code, title 42, sections 1396 et seq., as amended, for the provision of services to persons who, in the absence of the services, would need the level of care provided in a regional treatment center or a community intermediate care facility for persons with developmental disabilities. The commissioner may seek amendments to the waivers or apply for additional waivers under United States Code, title 42, sections 1396 et seq., as amended, to contain costs. The commissioner shall ensure that payment for the cost of providing home and community-based alternative

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services under the federal waiver plan shall not exceed the cost of intermediate care services including day training and habilitation services that would have been provided without the waivered services.

The commissioner shall seek an amendment to the 1915c home and community-based waiver to allow properly licensed adult foster care homes to provide residential services to up to five individuals with developmental disabilities. If the amendment to the waiver is approved, adult foster care providers that can accommodate five individuals shall increase their capacity to five beds, provided the providers continue to meet all applicable licensing requirements.

(b) The commissioner, in administering home and community-based waivers for persons with developmental disabilities, shall ensure that day services for eligible persons are not provided by the person's residential service provider, unless the person or the person's legal representative is offered a choice of providers and agrees in writing to provision of day services by the residential service provider. The coordinated service and support plan for individuals who choose to have their residential service provider provide their day services must describe how health, safety, protection, and habilitation needs will be met, including how frequent and regular contact with persons other than the residential service provider will occur. The coordinated service and support plan must address the provision of services during the day outside the residence on weekdays.

(c) When a lead agency is evaluating denials, reductions, or terminations of home and community-based services under section 256B.0916 for an individual, the lead agency shall offer to meet with the individual or the individual's guardian in order to discuss the prioritization of service needs within the coordinated service and support plan. The reduction in the authorized services for an individual due to changes in funding for waivered services may not exceed the amount needed to ensure medically necessary services to meet the individual's health, safety, and welfare.

Subd. 5a. [Repealed, 2009 c 79 art 1 s 21]

Subd. 5b. **Revised per diem based on legislated rate reduction.** Notwithstanding section 252.28, subdivision 3, paragraph (d), if the 2009 legislature adopts a rate reduction that impacts payment to providers of adult foster care services, the commissioner may issue adult foster care licenses that permit a capacity of five adults. The application for a five-bed license must meet the requirements of section 245A.11, subdivision 2a. Prior to admission of the fifth recipient of adult foster care services, the county must negotiate a revised per diem rate for room and board and waiver services that reflects the legislated rate reduction and results in an overall average per diem reduction for all foster care recipients in that home. The revised per diem must allow the provider to maintain, as much as possible, the level of services or enhanced services provided in the residence, while mitigating the losses of the legislated rate reduction.

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

Subd. 7. **Assessments.** (a) Assessments and reassessments shall be conducted by certified assessors according to section 256B.0911, and must incorporate appropriate referrals to determine eligibility for case management under subdivision 1a.

(b) For persons with developmental disabilities, a certified assessor shall evaluate the need for an institutional level of care. The assessment shall address whether home and community-based services are appropriate for persons who are at risk of placement in an intermediate care facility for persons with devel-

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opmental disabilities, or for whom there is reasonable indication that they might require this level of care. The certified assessor shall make an evaluation of need within five working days of an emergency admission of a person to an intermediate care facility for persons with developmental disabilities.

(c) The certified assessor, with the concurrence of the person, the person's legal guardian or conservator, or the parent if the person is a minor, may invite other individuals to attend the assessment. With the permission of the person being assessed or the person's designated legal representative, the person's current provider of services may submit a written report outlining their recommendations regarding the person's care needs prepared by a direct service employee with at least 20 hours of service to that client. The assessor must notify the provider of the date by which this information is to be submitted. This information must be provided to the assessor and the person or the person's legal representative and must be considered prior to the finalization of the assessment.

(d) Upon federal approval, if during an assessment or reassessment the recipient is determined to be able to have the recipient's needs met through alternative services in a less restrictive setting, the case manager shall help the recipient develop a plan to transition to an appropriate less restrictive setting.

Subd. 8. **Additional certified assessor duties.** In addition to the responsibilities of certified assessors described in section 256B.0911, for persons with developmental disabilities, the certified assessor shall:

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

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

(3) make recommendations regarding placement and payment for:

(i) social service or public assistance support, or both, to maintain a person in the person's own home or other place of residence;

(ii) training and habilitation service, vocational rehabilitation, and employment training activities;

(iii) community residential service placement;

(iv) regional treatment center placement; or

(v) a home and community-based service alternative to community residential service or regional treatment center placement including self-directed service options;

(4) evaluate the availability, location, and quality of the services listed in clause (3), including the impact of placement alternatives on the person's ability to maintain or improve existing patterns of contact and involvement with parents and other family members;

(5) identify the cost implications of recommendations in clause (3); and

(6) make recommendations to a court as may be needed to assist the court in making decisions regarding commitment of persons with developmental disabilities.

Subd. 8a. **County notification.** (a) If the county of financial responsibility wishes to place a person in another county for services, the county of financial responsibility shall notify the proposed county of service and the placement shall be made cooperatively between the two counties. Arrangements shall be made between the two counties for ongoing social service, including annual reviews of the person's coordinated

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service and support plan. The county where services are provided may not make changes in the person's coordinated service and support plan without approval by the county of financial responsibility.

(b) The county of service shall notify the county of financial responsibility if, in the case of an intermediate care facility for persons with developmental disabilities, there has been no authorization for admission by the admission review team as required in section 256B.0926.

(c) The county of service shall notify the county of financial responsibility of any concerns about the chosen provider's capacity to meet the needs of the person seeking to move to residential services in another county no later than 20 working days following receipt of the written notification. Unless other mutually acceptable arrangements are made by the involved county agencies, the county of financial responsibility is responsible for costs of social services and the costs associated with the development and maintenance of the placement. The county of service may request that the county of financial responsibility purchase case management services from the county of service or from a contracted provider of case management when the county of financial responsibility is not providing case management as defined in this section and rules adopted under this section, unless other mutually acceptable arrangements are made by the involved county agencies. Standards for payment limits under this section may be established by the commissioner. Financial disputes between counties shall be resolved as provided in section 256G.09. This subdivision also applies to home and community-based waiver services provided under section 256B.49.

Subd. 9. **Reimbursement.** Payment for services shall not be provided to a service provider for any person placed in an intermediate care facility for persons with developmental disabilities prior to the person receiving an assessment by a certified assessor. The commissioner shall not deny reimbursement for: (1) a person admitted to an intermediate care facility for persons with developmental disabilities who is assessed to need long-term supportive services, if long-term supportive services other than intermediate care are not available in that community; (2) any person admitted to an intermediate care facility for persons with developmental disabilities under emergency circumstances; (3) any eligible person placed in the intermediate care facility for persons with developmental disabilities pending an appeal of the certified assessor's decision; or (4) any medical assistance recipient when, after full discussion of all appropriate alternatives including those that are expected to be less costly than intermediate care for persons with developmental disabilities, the person or the person's legal guardian or conservator, or the parent if the person is a minor, insists on intermediate care placement. The certified assessor shall provide documentation that the most cost-effective alternatives available were offered to this individual or the individual's legal guardian or conservator.

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

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

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to assistance available to individuals interested in establishing private guardianships under the provisions of section 252A.03. The screening team meeting shall be conducted according to subdivisions 7 and 8. Discharge of the person shall not go forward without consensus of the screening team.

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

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

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

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

Subd. 11. **Residential support services.** (a) Upon federal approval, there is established a new service called residential support that is available on the community alternative care, community alternatives for disabled individuals, developmental disabilities, and brain injury waivers. Existing waiver service descriptions must be modified to the extent necessary to ensure there is no duplication between other services.

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Residential support services must be provided by vendors licensed as a community residential setting as defined in section 245A.11, subdivision 8, a foster care setting licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or an adult foster care setting licensed under Minnesota Rules, parts 9555.5105 to 9555.6265.

(b) Residential support services must meet the following criteria:

(1) the residential site must have a designated person responsible for program management, oversight, development, and implementation of policies and procedures;

(2) the provider of residential support services must provide supervision, training, and assistance as described in the person's coordinated service and support plan; and

(3) the provider of residential support services must meet the requirements of licensure and additional requirements of the person's coordinated service and support plan.

(c) Providers of residential support services that meet the definition in paragraph (a) must be licensed according to chapter 245D. Providers licensed to provide child foster care under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, and that meet the requirements in section 245A.03, subdivision 7, paragraph (f), are considered registered under this section.

Subd. 12. **Waivered services statewide priorities.** (a) The commissioner shall establish statewide priorities for individuals on the waiting list for developmental disabilities (DD) waiver services, as of January 1, 2010. The statewide priorities must include, but are not limited to, individuals who continue to have a need for waiver services after they have maximized the use of state plan services and other funding resources, including natural supports, prior to accessing waiver services, and who meet at least one of the following criteria:

(1) no longer require the intensity of services provided where they are currently living; or

(2) make a request to move from an institutional setting.

(b) After the priorities in paragraph (a) are met, priority must also be given to individuals who meet at least one of the following criteria:

(1) have unstable living situations due to the age, incapacity, or sudden loss of the primary caregivers;

(2) are moving from an institution due to bed closures;

(3) experience a sudden closure of their current living arrangement;

(4) require protection from confirmed abuse, neglect, or exploitation;

(5) experience a sudden change in need that can no longer be met through state plan services or other funding resources alone; or

(6) meet other priorities established by the department.

(c) When allocating resources to lead agencies, the commissioner must take into consideration the number of individuals waiting who meet statewide priorities and the lead agencies' current use of waiver funds and existing service options. The commissioner has the authority to transfer funds between counties,

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groups of counties, and tribes to accommodate statewide priorities and resource needs while accounting for a necessary base level reserve amount for each county, group of counties, and tribe.

Subd. 13. **Waiver allocations for transition populations.** (a) The commissioner shall make available additional waiver allocations and additional necessary resources to assure timely discharges from the Anoka Metro Regional Treatment Center and the Minnesota Security Hospital in St. Peter for individuals who meet the following criteria:

(1) are otherwise eligible for the developmental disabilities waiver under this section;

(2) who would otherwise remain at the Anoka Metro Regional Treatment Center or the Minnesota Security Hospital;

(3) whose discharge would be significantly delayed without the available waiver allocation; and

(4) who have met treatment objectives and no longer meet hospital level of care.

(b) Additional waiver allocations under this subdivision must meet cost-effectiveness requirements of the federal approved waiver plan.

(c) Any corporate foster care home developed under this subdivision must be considered an exception under section 245A.03, subdivision 7, paragraph (a).

Subd. 14. **Reduce avoidable behavioral crisis emergency room admissions, psychiatric inpatient hospitalizations, and commitments to institutions.** (a) Persons receiving home and community-based services authorized under this section who have had two or more admissions within a calendar year to an emergency room, psychiatric unit, or institution must receive consultation from a mental health professional as defined in section 245.462, subdivision 18, or a behavioral professional as defined in the home and community-based services state plan within 30 days of discharge. The mental health professional or behavioral professional must:

(1) conduct a functional assessment of the crisis incident as defined in section 245D.02, subdivision 11, which led to the hospitalization with the goal of developing proactive strategies as well as necessary reactive strategies to reduce the likelihood of future avoidable hospitalizations due to a behavioral crisis;

(2) use the results of the functional assessment to amend the coordinated service and support plan set forth in section 245D.02, subdivision 4b, to address the potential need for additional staff training, increased staffing, access to crisis mobility services, mental health services, use of technology, and crisis stabilization services in section 256B.0624, subdivision 7; and

(3) identify the need for additional consultation, testing, and mental health crisis intervention team services as defined in section 245D.02, subdivision 20, psychotropic medication use and monitoring under section 245D.051, and the frequency and duration of ongoing consultation.

(b) For the purposes of this subdivision, "institution" includes, but is not limited to, the Anoka-Metro Regional Treatment Center and the Minnesota Security Hospital.

History: *1983 c 312 art 9 s 5; 1984 c 640 s 32; 1985 c 21 s 55; 1Sp1985 c 9 art 2 s 40-45; 1987 c 305 s 2; 1988 c 689 art 2 s 148,149; 1989 c 282 art 3 s 61; art 6 s 29,30; 1990 c 568 art 3 s 57-61; 1990 c 599 s 1; 1991 c 292 art 6 s 47; 1992 c 513 art 7 s 74; art 9 s 26,27; 1993 c 339 s 15-19; 1995 c 207 art 3 s 19; art 8 s 34; 1997 c 7 art 5 s 30; 1Sp2001 c 9 art 3 s 46; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 3 s 31,32;*

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art 6 s 50,51; art 11 s 11; 2005 c 56 s 1; 2005 c 98 art 2 s 7; 2007 c 112 s 50; 2009 c 79 art 1 s 18; art 8 s 52-54; 2010 c 329 art 1 s 18; 2010 c 352 art 2 s 15; 2012 c 216 art 9 s 24; art 11 s 23-35; art 14 s 2; 2012 c 247 art 4 s 26,27; 2013 c 63 s 11; 2013 c 108 art 4 s 21; art 7 s 9-12; art 8 s 49,50; 2014 c 312 art 27 s 77

256B.0922 ESSENTIAL COMMUNITY SUPPORTS.

Subdivision 1. **Essential community supports.** (a) The purpose of the essential community supports program is to provide targeted services to persons age 65 and older who need essential community support, but whose needs do not meet the level of care required for nursing facility placement under section 144.0724, subdivision 11.

(b) Essential community supports are available not to exceed $400 per person per month. Essential community supports may be used as authorized within an authorization period not to exceed 12 months. Services must be available to a person who:

(1) is age 65 or older;

(2) is not eligible for medical assistance;

(3) has received a community assessment under section 256B.0911, subdivision 3a or 3b, and does not require the level of care provided in a nursing facility;

(4) meets the financial eligibility criteria for the alternative care program under section 256B.0913, subdivision 4;

(5) has a community support plan; and

(6) has been determined by a community assessment under section 256B.0911, subdivision 3a or 3b, to be a person who would require provision of at least one of the following services, as defined in the approved elderly waiver plan, in order to maintain their community residence:

(i) adult day services;

(ii) caregiver support;

(iii) homemaker support;

(iv) chores;

(v) a personal emergency response device or system;

(vi) home-delivered meals; or

(vii) community living assistance as defined by the commissioner.

(c) The person receiving any of the essential community supports in this subdivision must also receive service coordination, not to exceed $600 in a 12-month authorization period, as part of their community support plan.

(d) A person who has been determined to be eligible for essential community supports must be re-assessed at least annually and continue to meet the criteria in paragraph (b) to remain eligible for essential community supports.

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(e) The commissioner is authorized to use federal matching funds for essential community supports as necessary and to meet demand for essential community supports as outlined in subdivision 2, and that amount of federal funds is appropriated to the commissioner for this purpose.

Subd. 2. **Essential community supports for people in transition.** (a) Essential community supports under subdivision 1 are also available to an individual who:

(1) is receiving nursing facility services or home and community-based long-term services and supports under section 256B.0915 or 256B.49 on the effective date of implementation of the revised nursing facility level of care under section 144.0724, subdivision 11;

(2) meets one of the following criteria:

(i) due to the implementation of the revised nursing facility level of care, loses eligibility for continuing medical assistance payment of nursing facility services at the first reassessment under section 144.0724, subdivision 11, paragraph (b), that occurs on or after the effective date of the revised nursing facility level of care criteria under section 144.0724, subdivision 11; or

(ii) due to the implementation of the revised nursing facility level of care, loses eligibility for continuing medical assistance payment of home and community-based long-term services and supports under section 256B.0915 or 256B.49 at the first reassessment required under those sections that occurs on or after the effective date of implementation of the revised nursing facility level of care under section 144.0724, subdivision 11;

(3) is not eligible for personal care attendant services; and

(4) has an assessed need for one or more of the supportive services offered under essential community supports under subdivision 1, paragraph (b), clause (6).

Individuals eligible under this paragraph includes individuals who continue to be eligible for medical assistance state plan benefits and those who are not or are no longer financially eligible for medical assistance.

(b) Additional onetime case management is available for participants under paragraph (a), not to exceed $600 per person to be used within one authorization period not to exceed 12 months. This service is provided in addition to the essential community supports benefit described under subdivision 1, paragraph (b).

History: *2013 c 108 art 7 s 13; 2014 c 291 art 8 s 8*

256B.0924 TARGETED CASE MANAGEMENT SERVICES.

Subdivision 1. **Purpose.** The state recognizes that targeted case management services can decrease the need for more costly services such as multiple emergency room visits or hospitalizations by linking eligible individuals with less costly services available in the community.

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

(a) "Targeted case management" means services which will assist medical assistance eligible persons to gain access to needed medical, social, educational, and other services. Targeted case management does not include therapy, treatment, legal, or outreach services.

(b) "Targeted case management for adults" means activities that coordinate and link social and other services designed to help eligible persons gain access to needed protective services, social, health care,

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mental health, habilitative, educational, vocational, recreational, advocacy, legal, chemical, health, and other related services.

Subd. 3. **Eligibility.** Persons are eligible to receive targeted case management services under this section if the requirements in paragraphs (a) and (b) are met.

(a) The person must be assessed and determined by the local county agency to:

(1) be age 18 or older;

(2) be receiving medical assistance;

(3) have significant functional limitations; and

(4) be in need of service coordination to attain or maintain living in an integrated community setting.

(b) The person must be a vulnerable adult in need of adult protection as defined in section 626.5572, or is an adult with a developmental disability as defined in section 252A.02, subdivision 2, or a related condition as defined in section 252.27, subdivision 1a, and is not receiving home and community-based waiver services, or is an adult who lacks a permanent residence and who has been without a permanent residence for at least one year or on at least four occasions in the last three years.

Subd. 4. **Targeted case management service activities.** (a) For persons with developmental disabilities, targeted case management services must meet the provisions of section 256B.092.

(b) For persons not eligible as a person with a developmental disability, targeted case management service activities include:

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

(2) the development of a written personal service plan;

(3) a regular review and revision of the written personal service plan with the recipient and the recipient's legal representative, and others as identified by the recipient, to ensure access to necessary services and supports identified in the plan;

(4) effective communication with the recipient and the recipient's legal representative and others identified by the recipient;

(5) coordination of referrals for needed services with qualified providers;

(6) coordination and monitoring of the overall service delivery to ensure the quality and effectiveness of services;

(7) assistance to the recipient and the recipient's legal representative to help make an informed choice of services;

(8) advocating on behalf of the recipient when service barriers are encountered or referring the recipient and the recipient's legal representative to an independent advocate;

(9) monitoring and evaluating services identified in the personal service plan to ensure personal outcomes are met and to ensure satisfaction with services and service delivery;

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(10) conducting face-to-face monitoring with the recipient at least twice a year;

(11) completing and maintaining necessary documentation that supports and verifies the activities in this section;

(12) coordinating with the medical assistance facility discharge planner prior to the recipient's discharge into the community; and

(13) a personal service plan developed and reviewed at least annually with the recipient and the recipient's legal representative. The personal service plan must be revised when there is a change in the recipient's status. The personal service plan must identify:

(i) the desired personal short and long-term outcomes;

(ii) the recipient's preferences for services and supports, including development of a person-centered plan if requested; and

(iii) formal and informal services and supports based on areas of assessment, such as: social, health, mental health, residence, family, educational and vocational, safety, legal, self-determination, financial, and chemical health as determined by the recipient and the recipient's legal representative and the recipient's support network.

Subd. 5. **Provider standards.** County boards or providers who contract with the county are eligible to receive medical assistance reimbursement for adult targeted case management services. To qualify as a provider of targeted case management services the vendor must:

(1) have demonstrated the capacity and experience to provide the activities of case management services defined in subdivision 4;

(2) be able to coordinate and link community resources needed by the recipient;

(3) have the administrative capacity and experience to serve the eligible population in providing services and to ensure quality of services under state and federal requirements;

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

(5) have the capacity to document and maintain individual case records complying with state and federal requirements;

(6) coordinate with county social service agencies responsible for planning for community social services under chapters 256E and 256F; conducting adult protective investigations under section 626.557, and conducting prepetition screenings for commitments under section 253B.07;

(7) coordinate with health care providers to ensure access to necessary health care services;

(8) have a procedure in place that notifies the recipient and the recipient's legal representative of any conflict of interest if the contracted targeted case management service provider also provides the recipient's services and supports and provides information on all potential conflicts of interest and obtains the recipient's informed consent and provides the recipient with alternatives; and

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(9) have demonstrated the capacity to achieve the following performance outcomes: access, quality, and consumer satisfaction.

Subd. 6. **Payment for targeted case management.** (a) Medical assistance and MinnesotaCare payment for targeted case management shall be made on a monthly basis. In order to receive payment for an eligible adult, the provider must document at least one contact per month and not more than two consecutive months without a face-to-face contact with the adult or the adult's legal representative, family, primary caregiver, or other relevant persons identified as necessary to the development or implementation of the goals of the personal service plan.

(b) Payment for targeted case management provided by county staff under this subdivision shall be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph (b), calculated as one combined average rate together with adult mental health case management under section 256B.0625, subdivision 20, except for calendar year 2002. In calendar year 2002, the rate for case management under this section shall be the same as the rate for adult mental health case management in effect as of December 31, 2001. Billing and payment must identify the recipient's primary population group to allow tracking of revenues.

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

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

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

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

(g) The commissioner shall set aside five percent of the federal funds received under this section for use in reimbursing the state for costs of developing and implementing this section.

(h) Payments to counties for targeted case management expenditures under this section shall only be made from federal earnings from services provided under this section. Payments to contracted vendors shall include both the federal earnings and the county share.

(i) Notwithstanding section 256B.041, county payments for the cost of case management services provided by county staff shall not be made to the commissioner of management and budget. For the purposes

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of targeted case management services provided by county staff under this section, the centralized disbursement of payments to counties under section 256B.041 consists only of federal earnings from services provided under this section.

(j) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital, and the recipient's institutional care is paid by medical assistance, payment for targeted case management services under this subdivision is limited to the lesser of:

(1) the last 180 days of the recipient's residency in that facility; or

(2) the limits and conditions which apply to federal Medicaid funding for this service.

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

(l) Any growth in targeted case management services and cost increases under this section shall be the responsibility of the counties.

Subd. 7. **Implementation and evaluation.** The commissioner of human services in consultation with county boards shall establish a program to accomplish the provisions of subdivisions 1 to 6. The commissioner in consultation with county boards shall establish performance measures to evaluate the effectiveness of the targeted case management services. If a county fails to meet agreed-upon performance measures, the commissioner may authorize contracted providers other than the county. Providers contracted by the commissioner shall also be subject to the standards in subdivision 6.

History: *1Sp2001 c 9 art 2 s 44; 2002 c 277 s 18; 2002 c 375 art 2 s 31; 2002 c 379 art 1 s 113; 2003 c 112 art 2 s 50; 2005 c 56 s 1; 1Sp2005 c 4 art 3 s 9; 2008 c 363 art 15 s 6,7; 2009 c 101 art 2 s 109*

256B.0925 [Repealed, 1995 c 186 s 51]

256B.0926 ADMISSION REVIEW TEAM; INTERMEDIATE CARE FACILITIES.

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

(b) "Provider" means a provider of community-based intermediate care facility services for persons with developmental disabilities.

(c) "Facility" means a community-based intermediate care facility for persons with developmental disabilities.

(d) "Person" means a person with a developmental disability who is applying for admission to an intermediate care facility for persons with developmental disabilities.

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

(b) The admission review team must be assembled pursuant to Code of Federal Regulations, title 42, section 483.440(b)(2). The composition of the admission review team must meet the definition of an inter-

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disciplinary team in Code of Federal Regulations, title 42, section 483.440. In addition, the admission review team must meet any conditions agreed to by the provider and the county where services are to be provided.

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

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

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

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

(4) a representative of the provider.

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

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

(1) the preferences of the person and the person's guardian or family for services of an intermediate care facility for persons with developmental disabilities;

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

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

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

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

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

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

(2) a written description of the services that are available to the person seeking admission, including day services, professional support services, emergency services, available direct care staffing, supervisory and

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administrative supports, quality assurance systems, and criteria established by the provider for discharging persons from the facility.

Subd. 5. **Establishment of admission review team; notice to provider.** When a county agency decides to establish admission review teams for the intermediate care facilities for persons with developmental disabilities located in the county, the county agency shall notify the providers of the county agency's intent at least 60 days prior to establishing the teams.

History: *1991 c 292 art 6 s 48; 2005 c 56 s 1; 2011 c 86 s 19*

256B.0928 [Repealed, 2014 c 262 art 4 s 9]

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

Subdivision 1. **State traumatic brain injury program.** The commissioner of human services shall:

(1) maintain a statewide traumatic brain injury program;

(2) supervise and coordinate services and policies for persons with traumatic brain injuries;

(3) contract with qualified agencies or employ staff to provide statewide administrative case management and consultation;

(4) maintain an advisory committee to provide recommendations in reports to the commissioner regarding program and service needs of persons with brain injuries;

(5) investigate the need for the development of rules or statutes for the brain injury home and community-based services waiver;

(6) investigate present and potential models of service coordination which can be delivered at the local level; and

(7) the advisory committee required by clause (4) must consist of no fewer than ten members and no more than 30 members. The commissioner shall appoint all advisory committee members to one- or two-year terms and appoint one member as chair. The advisory committee does not terminate until June 30, 2018.

Subd. 2. **Eligibility.** Persons eligible for traumatic brain injury administrative case management and consultation must be eligible medical assistance recipients who have traumatic or certain acquired brain injury and are at risk of institutionalization.

Subd. 3. **Traumatic brain injury program duties.** The department shall fund administrative case management under this subdivision using medical assistance administrative funds. The traumatic brain injury program duties include:

(1) recommending to the commissioner in consultation with the medical review agent according to Minnesota Rules, parts 9505.0500 to 9505.0540, the approval or denial of medical assistance funds to pay for out-of-state placements for traumatic brain injury services and in-state traumatic brain injury services provided by designated Medicare long-term care hospitals;

(2) coordinating the brain injury home and community-based waiver;

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(3) providing ongoing technical assistance and consultation to county and facility case managers to facilitate care plan development for appropriate, accessible, and cost-effective medical assistance services;

(4) providing technical assistance to promote statewide development of appropriate, accessible, and cost-effective medical assistance services and related policy;

(5) providing training and outreach to facilitate access to appropriate home and community-based services to prevent institutionalization;

(6) facilitating appropriate admissions, continued stay review, discharges, and utilization review for neurobehavioral hospitals and other specialized institutions;

(7) providing technical assistance on the use of prior authorization of home care services and coordination of these services with other medical assistance services;

(8) developing a system for identification of nursing facility and hospital residents with traumatic brain injury to assist in long-term planning for medical assistance services. Factors will include, but are not limited to, number of individuals served, length of stay, services received, and barriers to community placement; and

(9) providing information, referral, and case consultation to access medical assistance services for recipients without a county or facility case manager. Direct access to this assistance may be limited due to the structure of the program.

Subd. 3a. **Traumatic brain injury case management services.** The annual appropriation established under section 171.29, subdivision 2, paragraph (c), shall be used for traumatic brain injury program services that include, but are not limited to:

(1) collaborating with counties, providers, and other public and private organizations to expand and strengthen local capacity for delivering needed services and supports, including efforts to increase access to supportive residential housing options;

(2) participating in planning and accessing services not otherwise covered in subdivision 3 to allow individuals to attain and maintain community-based services;

(3) providing information, referral, and case consultation to access health and human services for persons with traumatic brain injury not eligible for medical assistance, though direct access to this assistance may be limited due to the structure of the program; and

(4) collaborating on injury prevention efforts.

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

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

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

History: *1989 c 282 art 3 s 62; 1991 c 292 art 7 s 19; 1992 c 513 art 7 s 76-78; 1Sp1993 c 1 art 5 s 80,81; 1995 c 207 art 6 s 75-78; 1996 c 451 art 5 s 25; 2001 c 161 s 48; 1Sp2001 c 9 art 3 s 47; 2002 c*

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379 art 1 s 113; 1Sp2005 c 4 art 3 s 10; 2006 c 212 art 3 s 20; 2008 c 286 art 1 s 8; 2012 c 216 art 14 s 2; 2012 c 271 s 3; 2013 c 142 art 2 s 4; 2014 c 286 art 7 s 10

256B.094 CHILD WELFARE TARGETED CASE MANAGEMENT SERVICES.

Subdivision 1. **Definition.** "Child welfare targeted case management services" means activities that coordinate social and other services designed to help the child under age 21 and the child's family gain access to needed social services, mental health services, habilitative services, educational services, health services, vocational services, recreational services, and related services including, but not limited to, the areas of volunteer services, advocacy, transportation, and legal services. Case management services include developing an individual service plan and assisting the child and the child's family in obtaining needed services through coordination with other agencies and assuring continuity of care. Case managers must assess the delivery, appropriateness, and effectiveness of services on a regular basis.

Subd. 2. **Eligible services.** Services eligible for medical assistance reimbursement include:

(1) assessment of the recipient's need for case management services to gain access to medical, social, educational, and other related services;

(2) development, completion, and regular review of a written individual service plan based on the assessment of need for case management services to ensure access to medical, social, educational, and other related services;

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

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

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

(6) monitoring and evaluating services on a regular basis to ensure appropriateness and continued need;

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

(8) traveling to conduct a visit with the client or other relevant person necessary to the development or implementation of the goals of the individual service plan; and

(9) coordinating with the medical assistance facility discharge planner in the 30-day period before the client's discharge into the community. This case management service provided to patients or residents in a medical assistance facility is limited to a maximum of two 30-day periods per calendar year.

Subd. 3. **Coordination and provision of services.** (a) In a county or reservation where a prepaid medical assistance provider has contracted under section 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

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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.

Subd. 4. **Case management provider.** To be eligible to receive medical assistance reimbursement, the case management provider must meet all provider qualification and certification standards under section 256F.10.

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, or a client served by tribal social services placed outside the reservation, in an excluded time facility under section 256G.02, subdivision 6, or through the Interstate Compact for the Placement of Children, section 260.93, and the placement in either case is more than 60 miles beyond the county or reservation boundaries, there must be at least one contact per month and not more than two consecutive months without a face-to-face contact.

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

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

(d) Payment for case management provided by county or tribal social services contracted vendors shall be based on a monthly rate negotiated by the host county or tribal social services. The negotiated rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the county or tribal social services may negotiate a team rate with a vendor

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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.

Subd. 7. **Documentation for case record and claim.** (a) The assessment, case finding, and individual service plan shall be maintained in the individual case record under the Data Practices Act, chapter 13. The individual service plan must be reviewed at least annually and updated as necessary. Each individual case record must maintain documentation of routine, ongoing, contacts and services. Each claim must be supported by written documentation in the individual case record.

(b) Each claim must include:

(1) the name of the recipient;

(2) the date of the service;

(3) the name of the provider agency and the person providing service;

(4) the nature and extent of services; and

(5) the place of the services.

Subd. 8. **Payment limitation.** Services that are not eligible for payment as a child welfare targeted case management service include, but are not limited to:

(1) assessments prior to opening a case;

(2) therapy and treatment services;

(3) legal services, including legal advocacy, for the client;

(4) information and referral services that are not provided to an eligible recipient;

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(5) outreach services including outreach services provided through the community support services program;

(6) services that are not documented as required under subdivision 7 and Minnesota Rules, parts 9505.2165 and 9505.2175;

(7) services that are otherwise eligible for payment on a separate schedule under rules of the Department of Human Services;

(8) services to a client that duplicate the same case management service from another case manager;

(9) case management services provided to patients or residents in a medical assistance facility except as described under subdivision 2, clause (9); and

(10) for children in foster care, group homes, or residential care, payment for case management services is limited to case management services that focus on permanency planning or return to the family home and that do not duplicate the facility's discharge planning services.

History: *1Sp1993 c 1 art 3 s 24; 1999 c 139 art 4 s 2; 1999 c 245 art 8 s 6-8; 2000 c 488 art 9 s 17; 2001 c 203 s 11,12; 1Sp2003 c 14 art 11 s 11; 2005 c 98 art 2 s 8; 2008 c 361 art 6 s 58; 2009 c 163 art 1 s 8; 2009 c 173 art 3 s 11; 2012 c 187 art 1 s 38*

256B.0943 CHILDREN'S THERAPEUTIC SERVICES AND SUPPORTS.

Subdivision 1. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Children's therapeutic services and supports" means the flexible package of mental health services for children who require varying therapeutic and rehabilitative levels of intervention. The services are time-limited interventions that are delivered using various treatment modalities and combinations of services designed to reach treatment outcomes identified in the individual treatment plan.

(b) "Clinical supervision" means the overall responsibility of the mental health professional for the control and direction of individualized treatment planning, service delivery, and treatment review for each client. A mental health professional who is an enrolled Minnesota health care program provider accepts full professional responsibility for a supervisee's actions and decisions, instructs the supervisee in the supervisee's work, and oversees or directs the supervisee's work.

(c) "County board" means the county board of commissioners or board established under sections 402.01 to 402.10 or 471.59.

(d) "Crisis assistance" has the meaning given in section 245.4871, subdivision 9a.

(e) "Culturally competent provider" means a provider who understands and can utilize to a client's benefit the client's culture when providing services to the client. A provider may be culturally competent because the provider is of the same cultural or ethnic group as the client or the provider has developed the knowledge and skills through training and experience to provide services to culturally diverse clients.

(f) "Day treatment program" for children means a site-based structured mental health program consisting of psychotherapy for three or more individuals and individual or group skills training provided by a multi-disciplinary team, under the clinical supervision of a mental health professional.

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(g) "Diagnostic assessment" has the meaning given in Minnesota Rules, part 9505.0372, subpart 1.

(h) "Direct service time" means the time that a mental health professional, mental health practitioner, or mental health behavioral aide spends face-to-face with a client and the client's family. Direct service time includes time in which the provider obtains a client's history or provides service components of children's therapeutic services and supports. Direct service time does not include time doing work before and after providing direct services, including scheduling, maintaining clinical records, consulting with others about the client's mental health status, preparing reports, receiving clinical supervision, and revising the client's individual treatment plan.

(i) "Direction of mental health behavioral aide" means the activities of a mental health professional or mental health practitioner in guiding the mental health behavioral aide in providing services to a client. The direction of a mental health behavioral aide must be based on the client's individualized treatment plan and meet the requirements in subdivision 6, paragraph (b), clause (5).

(j) "Emotional disturbance" has the meaning given in section 245.4871, subdivision 15. For persons at least age 18 but under age 21, mental illness has the meaning given in section 245.462, subdivision 20, paragraph (a).

(k) "Individual behavioral plan" means a plan of intervention, treatment, and services for a child written by a mental health professional or mental health practitioner, under the clinical supervision of a mental health professional, to guide the work of the mental health behavioral aide.

(l) "Individual treatment plan" has the meaning given in section 245.4871, subdivision 21.

(m) "Mental health behavioral aide services" means medically necessary one-on-one activities performed by a trained paraprofessional to assist a child retain or generalize psychosocial skills as taught by a mental health professional or mental health practitioner and as described in the child's individual treatment plan and individual behavior plan. Activities involve working directly with the child or child's family as provided in subdivision 9, paragraph (b), clause (4).

(n) "Mental health practitioner" means an individual as defined in section 245.4871, subdivision 26.

(o) "Mental health professional" means an individual as defined in section 245.4871, subdivision 27, clauses (1) to (6), or tribal vendor as defined in section 256B.02, subdivision 7, paragraph (b).

(p) "Mental health service plan development" includes:

(1) the development, review, and revision of a child's individual treatment plan, as provided in Minnesota Rules, part 9505.0371, subpart 7, including involvement of the client or client's parents, primary caregiver, or other person authorized to consent to mental health services for the client, and including arrangement of treatment and support activities specified in the individual treatment plan; and

(2) administering standardized outcome measurement instruments, determined and updated by the commissioner, as periodically needed to evaluate the effectiveness of treatment for children receiving clinical services and reporting outcome measures, as required by the commissioner.

(q) "Skills training" means individual, family, or group training, delivered by or under the direction of a mental health professional, designed to facilitate the acquisition of psychosocial skills that are medically necessary to rehabilitate the child to an age-appropriate developmental trajectory heretofore disrupted by a psychiatric illness or to self-monitor, compensate for, cope with, counteract, or replace skills deficits or

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maladaptive skills acquired over the course of a psychiatric illness. Skills training is subject to the following requirements:

(1) a mental health professional or a mental health practitioner must provide skills training;

(2) the child must always be present during skills training; however, a brief absence of the child for no more than ten percent of the session unit may be allowed to redirect or instruct family members;

(3) skills training delivered to children or their families must be targeted to the specific deficits or maladaptations of the child's mental health disorder and must be prescribed in the child's individual treatment plan;

(4) skills training delivered to the child's family must teach skills needed by parents to enhance the child's skill development and to help the child use in daily life the skills previously taught by a mental health professional or mental health practitioner and to develop or maintain a home environment that supports the child's progressive use skills;

(5) group skills training may be provided to multiple recipients who, because of the nature of their emotional, behavioral, or social dysfunction, can derive mutual benefit from interaction in a group setting, which must be staffed as follows:

(i) one mental health professional or one mental health practitioner under supervision of a licensed mental health professional must work with a group of four to eight clients; or

(ii) two mental health professionals or two mental health practitioners under supervision of a licensed mental health professional, or one professional plus one practitioner must work with a group of nine to 12 clients.

Subd. 2. **Covered service components of children's therapeutic services and supports.** (a) Subject to federal approval, medical assistance covers medically necessary children's therapeutic services and supports as defined in this section that an eligible provider entity certified under subdivision 4 provides to a client eligible under subdivision 3.

(b) The service components of children's therapeutic services and supports are:

(1) patient or family member, family, psychotherapy for crisis, and group psychotherapy;

(2) individual, family, or group skills training provided by a mental health professional or mental health practitioner;

(3) crisis assistance;

(4) mental health behavioral aide services;

(5) direction of a mental health behavioral aide;

(6) mental health service plan development; and

(7) children's day treatment.

Subd. 3. **Determination of client eligibility.** A client's eligibility to receive children's therapeutic services and supports under this section shall be determined based on a diagnostic assessment by a mental

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health professional or a mental health practitioner who meets the requirements as a clinical trainee as defined in Minnesota Rules, part 9505.0371, subpart 5, item C, that is performed within one year before the initial start of service. The diagnostic assessment must meet the requirements for a standard or extended diagnostic assessment as defined in Minnesota Rules, part 9505.0372, subpart 1, items B and C, and:

(1) include current diagnoses on all five axes of the client's current mental health status;

(2) determine whether a child under age 18 has a diagnosis of emotional disturbance or, if the person is between the ages of 18 and 21, whether the person has a mental illness;

(3) document children's therapeutic services and supports as medically necessary to address an identified disability, functional impairment, and the individual client's needs and goals;

(4) be used in the development of the individualized treatment plan; and

(5) be completed annually until age 18. A client with autism spectrum disorder or pervasive developmental disorder may receive a diagnostic assessment once every three years, at the request of the parent or guardian, if a mental health professional agrees there has been little change in the condition and that an annual assessment is not needed. For individuals between age 18 and 21, unless a client's mental health condition has changed markedly since the client's most recent diagnostic assessment, annual updating is necessary. For the purpose of this section, "updating" means an adult diagnostic update as defined in Minnesota Rules, part 9505.0371, subpart 2, item E.

Subd. 4. **Provider entity certification.** (a) Effective July 1, 2003, the commissioner shall establish an initial provider entity application and certification process and recertification process to determine whether a provider entity has an administrative and clinical infrastructure that meets the requirements in subdivisions 5 and 6. The commissioner shall recertify a provider entity at least every three years. The commissioner shall establish a process for decertification of a provider entity that no longer meets the requirements in this section.

(b) For purposes of this section, a provider entity must be:

(1) an Indian health services facility or a facility owned and operated by a tribe or tribal organization operating as a 638 facility under Public Law 93-638 certified by the state;

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

(3) a noncounty entity certified by the state.

Subd. 5. **Provider entity administrative infrastructure requirements.** (a) To be an eligible provider entity under this section, a provider entity must have an administrative infrastructure that establishes authority and accountability for decision making and oversight of functions, including finance, personnel, system management, clinical practice, and performance measurement. The provider must have written policies and procedures that it reviews and updates every three years and distributes to staff initially and upon each subsequent update.

(b) The administrative infrastructure written policies and procedures must include:

(1) personnel procedures, including a process for: (i) recruiting, hiring, training, and retention of culturally and linguistically competent providers; (ii) conducting a criminal background check on all direct

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service providers and volunteers; (iii) investigating, reporting, and acting on violations of ethical conduct standards; (iv) investigating, reporting, and acting on violations of data privacy policies that are compliant with federal and state laws; (v) utilizing volunteers, including screening applicants, training and supervising volunteers, and providing liability coverage for volunteers; and (vi) documenting that each mental health professional, mental health practitioner, or mental health behavioral aide meets the applicable provider qualification criteria, training criteria under subdivision 8, and clinical supervision or direction of a mental health behavioral aide requirements under subdivision 6;

(2) fiscal procedures, including internal fiscal control practices and a process for collecting revenue that is compliant with federal and state laws;

(3) a performance measurement system, including monitoring to determine cultural appropriateness of services identified in the individual treatment plan, as determined by the client's culture, beliefs, values, and language, and family-driven services; and

(4) a process to establish and maintain individual client records. The client's records must include:

(i) the client's personal information;

(ii) forms applicable to data privacy;

(iii) the client's diagnostic assessment, updates, results of tests, individual treatment plan, and individual behavior plan, if necessary;

(iv) documentation of service delivery as specified under subdivision 6;

(v) telephone contacts;

(vi) discharge plan; and

(vii) if applicable, insurance information.

(c) A provider entity that uses a restrictive procedure with a client must meet the requirements of section 245.8261.

Subd. 5a. **Background studies.** The requirements for background studies under this section may be met by a children's therapeutic services and supports services agency through the commissioner's NETStudy system as provided under sections 245C.03, subdivision 7, and 245C.10, subdivision 8.

Subd. 6. **Provider entity clinical infrastructure requirements.** (a) To be an eligible provider entity under this section, a provider entity must have a clinical infrastructure that utilizes diagnostic assessment, individualized treatment plans, service delivery, and individual treatment plan review that are culturally competent, child-centered, and family-driven to achieve maximum benefit for the client. The provider entity must review, and update as necessary, the clinical policies and procedures every three years and must distribute the policies and procedures to staff initially and upon each subsequent update.

(b) The clinical infrastructure written policies and procedures must include policies and procedures for:

(1) providing or obtaining a client's diagnostic assessment that identifies acute and chronic clinical disorders, co-occurring medical conditions, and sources of psychological and environmental problems,

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including a functional assessment. The functional assessment component must clearly summarize the client's individual strengths and needs;

(2) developing an individual treatment plan that:

(i) is based on the information in the client's diagnostic assessment;

(ii) identified goals and objectives of treatment, treatment strategy, schedule for accomplishing treatment goals and objectives, and the individuals responsible for providing treatment services and supports;

(iii) is developed after completion of the client's diagnostic assessment by a mental health professional and before the provision of children's therapeutic services and supports;

(iv) is developed through a child-centered, family-driven, culturally appropriate planning process;

(v) is reviewed at least once every 90 days and revised, if necessary; and

(vi) is signed by the clinical supervisor and by the client or by the client's parent or other person authorized by statute to consent to mental health services for the client;

(3) developing an individual behavior plan that documents treatment strategies to be provided by the mental health behavioral aide. The individual behavior plan must include:

(i) detailed instructions on the treatment strategies to be provided;

(ii) time allocated to each treatment strategy;

(iii) methods of documenting the child's behavior;

(iv) methods of monitoring the child's progress in reaching objectives; and

(v) goals to increase or decrease targeted behavior as identified in the individual treatment plan;

(4) providing clinical supervision of the mental health practitioner and mental health behavioral aide. A mental health professional must document the clinical supervision the professional provides by cosigning individual treatment plans and making entries in the client's record on supervisory activities. Clinical supervision does not include the authority to make or terminate court-ordered placements of the child. A clinical supervisor must be available for urgent consultation as required by the individual client's needs or the situation. Clinical supervision may occur individually or in a small group to discuss treatment and review progress toward goals. The focus of clinical supervision must be the client's treatment needs and progress and the mental health practitioner's or behavioral aide's ability to provide services;

(4a) meeting day treatment and therapeutic preschool programs conditions in items (i) to (iii):

(i) the supervisor must be present and available on the premises more than 50 percent of the time in a five-working-day period during which the supervisee is providing a mental health service;

(ii) the diagnosis and the client's individual treatment plan or a change in the diagnosis or individual treatment plan must be made by or reviewed, approved, and signed by the supervisor; and

(iii) every 30 days, the supervisor must review and sign the record indicating the supervisor has reviewed the client's care for all activities in the preceding 30-day period;

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(4b) meeting the clinical supervision standards in items (i) to (iv) for all other services provided under CTSS:

(i) medical assistance shall reimburse for services provided by a mental health practitioner who maintains a consulting relationship with a mental health professional who accepts full professional responsibility;

(ii) medical assistance shall reimburse for services provided by a mental health behavioral aide who maintains a consulting relationship with a mental health professional who accepts full professional responsibility and has an approved plan for clinical supervision of the behavioral aide. Plans will be developed in accordance with supervision standards defined in Minnesota Rules, part 9505.0371, subpart 4, items A to D;

(iii) the mental health professional is required to be present on site for observation as clinically appropriate when the mental health practitioner or mental health behavioral aide is providing CTSS services; and

(iv) when conducted, the on-site presence of the mental health professional must be documented in the child's record and signed by the mental health professional who accepts full professional responsibility;

(5) providing direction to a mental health behavioral aide. For entities that employ mental health behavioral aides, the clinical supervisor must be employed by the provider entity or other certified children's therapeutic supports and services provider entity to ensure necessary and appropriate oversight for the client's treatment and continuity of care. The mental health professional or mental health practitioner giving direction must begin with the goals on the individualized treatment plan, and instruct the mental health behavioral aide on how to construct therapeutic activities and interventions that will lead to goal attainment. The professional or practitioner giving direction must also instruct the mental health behavioral aide about the client's diagnosis, functional status, and other characteristics that are likely to affect service delivery. Direction must also include determining that the mental health behavioral aide has the skills to interact with the client and the client's family in ways that convey personal and cultural respect and that the aide actively solicits information relevant to treatment from the family. The aide must be able to clearly explain the activities the aide is doing with the client and the activities' relationship to treatment goals. Direction is more didactic than is supervision and requires the professional or practitioner providing it to continuously evaluate the mental health behavioral aide's ability to carry out the activities of the individualized treatment plan and the individualized behavior plan. When providing direction, the professional or practitioner must:

(i) review progress notes prepared by the mental health behavioral aide for accuracy and consistency with diagnostic assessment, treatment plan, and behavior goals and the professional or practitioner must approve and sign the progress notes;

(ii) identify changes in treatment strategies, revise the individual behavior plan, and communicate treatment instructions and methodologies as appropriate to ensure that treatment is implemented correctly;

(iii) demonstrate family-friendly behaviors that support healthy collaboration among the child, the child's family, and providers as treatment is planned and implemented;

(iv) ensure that the mental health behavioral aide is able to effectively communicate with the child, the child's family, and the provider; and

(v) record the results of any evaluation and corrective actions taken to modify the work of the mental health behavioral aide;

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(6) providing service delivery that implements the individual treatment plan and meets the requirements under subdivision 9; and

(7) individual treatment plan review. The review must determine the extent to which the services have met the goals and objectives in the previous treatment plan. The review must assess the client's progress and ensure that services and treatment goals continue to be necessary and appropriate to the client and the client's family or foster family. Revision of the individual treatment plan does not require a new diagnostic assessment unless the client's mental health status has changed markedly. The updated treatment plan must be signed by the clinical supervisor and by the client, if appropriate, and by the client's parent or other person authorized by statute to give consent to the mental health services for the child.

Subd. 7. **Qualifications of individual and team providers.** (a) An individual or team provider working within the scope of the provider's practice or qualifications may provide service components of children's therapeutic services and supports that are identified as medically necessary in a client's individual treatment plan.

(b) An individual provider must be qualified as:

(1) a mental health professional as defined in subdivision 1, paragraph (n); or

(2) a mental health practitioner or clinical trainee. The mental health practitioner or clinical trainee must work under the clinical supervision of a mental health professional; or

(3) a mental health behavioral aide working under the clinical supervision of a mental health professional to implement the rehabilitative mental health services previously introduced by a mental health professional or practitioner and identified in the client's individual treatment plan and individual behavior plan.

(A) A level I mental health behavioral aide must:

(i) be at least 18 years old;

(ii) have a high school diploma or general equivalency diploma (GED) or two years of experience as a primary caregiver to a child with severe emotional disturbance within the previous ten years; and

(iii) meet preservice and continuing education requirements under subdivision 8.

(B) A level II mental health behavioral aide must:

(i) be at least 18 years old;

(ii) have an associate or bachelor's degree or 4,000 hours of experience in delivering clinical services in the treatment of mental illness concerning children or adolescents or complete a certificate program established under subdivision 8a; and

(iii) meet preservice and continuing education requirements in subdivision 8.

(c) A day treatment multidisciplinary team must include at least one mental health professional or clinical trainee and one mental health practitioner.

Subd. 8. **Required preservice and continuing education.** (a) A provider entity shall establish a plan to provide preservice and continuing education for staff. The plan must clearly describe the type of training

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necessary to maintain current skills and obtain new skills and that relates to the provider entity's goals and objectives for services offered.

(b) A provider that employs a mental health behavioral aide under this section must require the mental health behavioral aide to complete 30 hours of preservice training. The preservice training must include parent team training. The preservice training must include 15 hours of in-person training of a mental health behavioral aide in mental health services delivery and eight hours of parent team training. Curricula for parent team training must be approved in advance by the commissioner. Components of parent team training include:

(1) partnering with parents;

(2) fundamentals of family support;

(3) fundamentals of policy and decision making;

(4) defining equal partnership;

(5) complexities of the parent and service provider partnership in multiple service delivery systems due to system strengths and weaknesses;

(6) sibling impacts;

(7) support networks; and

(8) community resources.

(c) A provider entity that employs a mental health practitioner and a mental health behavioral aide to provide children's therapeutic services and supports under this section must require the mental health practitioner and mental health behavioral aide to complete 20 hours of continuing education every two calendar years. The continuing education must be related to serving the needs of a child with emotional disturbance in the child's home environment and the child's family.

(d) The provider entity must document the mental health practitioner's or mental health behavioral aide's annual completion of the required continuing education. The documentation must include the date, subject, and number of hours of the continuing education, and attendance records, as verified by the staff member's signature, job title, and the instructor's name. The provider entity must keep documentation for each employee, including records of attendance at professional workshops and conferences, at a central location and in the employee's personnel file.

Subd. 8a. **Level II mental health behavioral aide.** The commissioner of human services, in collaboration with children's mental health providers and the Board of Trustees of the Minnesota State Colleges and Universities, shall develop a certificate program for level II mental health behavioral aides.

Subd. 9. **Service delivery criteria.** (a) In delivering services under this section, a certified provider entity must ensure that:

(1) each individual provider's caseload size permits the provider to deliver services to both clients with severe, complex needs and clients with less intensive needs. The provider's caseload size should reasonably enable the provider to play an active role in service planning, monitoring, and delivering services to meet the client's and client's family's needs, as specified in each client's individual treatment plan;

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(2) site-based programs, including day treatment and preschool programs, provide staffing and facilities to ensure the client's health, safety, and protection of rights, and that the programs are able to implement each client's individual treatment plan;

(3) a day treatment program is provided to a group of clients by a multidisciplinary team under the clinical supervision of a mental health professional. The day treatment program must be provided in and by: (i) an outpatient hospital accredited by the Joint Commission on Accreditation of Health Organizations and licensed under sections 144.50 to 144.55; (ii) a community mental health center under section 245.62; or (iii) an entity that is certified under subdivision 4 to operate a program that meets the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475. The day treatment program must stabilize the client's mental health status while developing and improving the client's independent living and socialization skills. The goal of the day treatment program must be to reduce or relieve the effects of mental illness and provide training to enable the client to live in the community. The program must be available at least one day a week for a two-hour time block. The two-hour time block must include at least one hour of individual or group psychotherapy. The remainder of the structured treatment program may include individual or group psychotherapy, and individual or group skills training, if included in the client's individual treatment plan. Day treatment programs are not part of inpatient or residential treatment services. A day treatment program may provide fewer than the minimally required hours for a particular child during a billing period in which the child is transitioning into, or out of, the program; and

(4) a therapeutic preschool program is a structured treatment program offered to a child who is at least 33 months old, but who has not yet reached the first day of kindergarten, by a preschool multidisciplinary team in a day program licensed under Minnesota Rules, parts 9503.0005 to 9503.0175. The program must be available two hours per day, five days per week, and 12 months of each calendar year. The structured treatment program may include individual or group psychotherapy and individual or group skills training, if included in the client's individual treatment plan. A therapeutic preschool program may provide fewer than the minimally required hours for a particular child during a billing period in which the child is transitioning into, or out of, the program.

(b) A provider entity must deliver the service components of children's therapeutic services and supports in compliance with the following requirements:

(1) individual, family, and group psychotherapy must be delivered as specified in Minnesota Rules, part 9505.0372, subpart 6;

(2) individual, family, or group skills training must be provided by a mental health professional or a mental health practitioner who has a consulting relationship with a mental health professional who accepts full professional responsibility for the training;

(3) crisis assistance must be time-limited and designed to resolve or stabilize crisis through arrangements for direct intervention and support services to the child and the child's family. Crisis assistance must utilize resources designed to address abrupt or substantial changes in the functioning of the child or the child's family as evidenced by a sudden change in behavior with negative consequences for well being, a loss of usual coping mechanisms, or the presentation of danger to self or others;

(4) mental health behavioral aide services must be medically necessary treatment services, identified in the child's individual treatment plan and individual behavior plan, which are performed minimally by a paraprofessional qualified according to subdivision 7, paragraph (b), clause (3), and which are designed to improve the functioning of the child in the progressive use of developmentally appropriate psychosocial

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skills. Activities involve working directly with the child, child-peer groupings, or child-family groupings to practice, repeat, reintroduce, and master the skills defined in subdivision 1, paragraph (p), as previously taught by a mental health professional or mental health practitioner including:

(i) providing cues or prompts in skill-building peer-to-peer or parent-child interactions so that the child progressively recognizes and responds to the cues independently;

(ii) performing as a practice partner or role-play partner;

(iii) reinforcing the child's accomplishments;

(iv) generalizing skill-building activities in the child's multiple natural settings;

(v) assigning further practice activities; and

(vi) intervening as necessary to redirect the child's target behavior and to de-escalate behavior that puts the child or other person at risk of injury.

A mental health behavioral aide must document the delivery of services in written progress notes. The mental health behavioral aide must implement treatment strategies in the individual treatment plan and the individual behavior plan. The mental health behavioral aide must document the delivery of services in written progress notes. Progress notes must reflect implementation of the treatment strategies, as performed by the mental health behavioral aide and the child's responses to the treatment strategies; and

(5) direction of a mental health behavioral aide must include the following:

(i) a clinical supervision plan approved by the responsible mental health professional;

(ii) ongoing face-to-face observation of the mental health behavioral aide delivering services to a child by a mental health professional or mental health practitioner for at least a total of one hour during every 40 hours of service provided to a child; and

(iii) immediate accessibility of the mental health professional or mental health practitioner to the mental health behavioral aide during service provision.

Subd. 10. **Service authorization.** Children's therapeutic services and supports are subject to authorization criteria and standards published by the commissioner according to section 256B.0625, subdivision 25.

Subd. 11. **Documentation and billing.** (a) A provider entity must document the services it provides under this section. The provider entity must ensure that the entity's documentation standards meet the requirements of federal and state laws. Services billed under this section that are not documented according to this subdivision shall be subject to monetary recovery by the commissioner. The provider entity may not bill for anything other than direct service time.

(b) An individual mental health provider must promptly document the following in a client's record after providing services to the client:

(1) each occurrence of the client's mental health service, including the date, type, length, and scope of the service;

(2) the name of the person who gave the service;

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(3) contact made with other persons interested in the client, including representatives of the courts, corrections systems, or schools. The provider must document the name and date of each contact;

(4) any contact made with the client's other mental health providers, case manager, family members, primary caregiver, legal representative, or the reason the provider did not contact the client's family members, primary caregiver, or legal representative, if applicable; and

(5) required clinical supervision, as appropriate.

Subd. 12. **Excluded services.** The following services are not eligible for medical assistance payment as children's therapeutic services and supports:

(1) service components of children's therapeutic services and supports simultaneously provided by more than one provider entity unless prior authorization is obtained;

(2) treatment by multiple providers within the same agency at the same clock time;

(3) children's therapeutic services and supports provided in violation of medical assistance policy in Minnesota Rules, part 9505.0220;

(4) mental health behavioral aide services provided by a personal care assistant who is not qualified as a mental health behavioral aide and employed by a certified children's therapeutic services and supports provider entity;

(5) service components of CTSS that are the responsibility of a residential or program license holder, including foster care providers under the terms of a service agreement or administrative rules governing licensure; and

(6) adjunctive activities that may be offered by a provider entity but are not otherwise covered by medical assistance, including:

(i) a service that is primarily recreation oriented or that is provided in a setting that is not medically supervised. This includes sports activities, exercise groups, activities such as craft hours, leisure time, social hours, meal or snack time, trips to community activities, and tours;

(ii) a social or educational service that does not have or cannot reasonably be expected to have a therapeutic outcome related to the client's emotional disturbance;

(iii) prevention or education programs provided to the community; and

(iv) treatment for clients with primary diagnoses of alcohol or other drug abuse.

Subd. 13. **Exception to excluded services.** Notwithstanding subdivision 12, up to 15 hours of children's therapeutic services and supports provided within a six-month period to a child with severe emotional disturbance who is residing in a hospital; a group home as defined in Minnesota Rules, parts 2960.0130 to 2960.0220; a residential treatment facility licensed under Minnesota Rules, parts 2960.0580 to 2960.0690; a regional treatment center; or other institutional group setting or who is participating in a program of partial hospitalization are eligible for medical assistance payment if part of the discharge plan.

History: *1Sp2003 c 14 art 4 s 8; 2004 c 228 art 1 s 38-42; 2005 c 98 art 2 s 9-11; 1Sp2005 c 4 art 2 s 11; 2007 c 147 art 8 s 22; art 11 s 18-21; 2008 c 234 s 4; 2009 c 79 art 7 s 19,21; 2009 c 142 art 2 s*

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38-40; 2009 c 167 s 14-20; 2010 c 303 s 5; 1Sp2011 c 9 art 3 s 4; 2012 c 247 art 5 s 4; 2013 c 59 art 1 s 2-5; 2013 c 108 art 4 s 22-25; 2014 c 262 art 3 s 12-17

256B.0944 CHILDREN'S MENTAL HEALTH CRISIS RESPONSE SERVICES.

Subdivision 1. **Definitions.** For purposes of this section, the following terms have the meanings given them.

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

(b) "Mental health emergency" means a child's behavioral, emotional, or psychiatric situation that causes an immediate need for mental health services and is consistent with section 62Q.55. A physician, mental health professional, or crisis mental health practitioner determines a mental health crisis or emergency for medical assistance reimbursement with input from the client and the client's family, if possible.

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

(d) "Mental health mobile crisis intervention services" means face-to-face, short-term intensive mental health services initiated during a mental health crisis or mental health emergency. Mental health mobile crisis services must help the recipient cope with immediate stressors, identify and utilize available resources and strengths, and begin to return to the recipient's baseline level of functioning. Mental health mobile services must be provided on site by a mobile crisis intervention team outside of an emergency room, urgent care, or an inpatient hospital setting.

(e) "Mental health crisis stabilization services" means individualized mental health services provided to a recipient following crisis intervention services that are designed to restore the recipient to the recipient's prior functional level. The individual treatment plan recommending mental health crisis stabilization must be completed by the intervention team or by staff after an inpatient or urgent care visit. Mental health crisis stabilization services may be provided in the recipient's home, the home of a family member or friend of the recipient, schools, another community setting, or a short-term supervised, licensed residential program if the service is not included in the facility's cost pool or per diem. Mental health crisis stabilization is not reimbursable when provided as part of a partial hospitalization or day treatment program.

Subd. 2. **Medical assistance coverage.** Medical assistance covers medically necessary children's mental health crisis response services, subject to federal approval, if provided to an eligible recipient under subdivision 3, by a qualified provider entity under subdivision 4 or a qualified individual provider working within the provider's scope of practice, and identified in the recipient's individual crisis treatment plan under subdivision 8.

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

(1) is eligible for medical assistance;

(2) is under age 18 or between the ages of 18 and 21;

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

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

(5) meets the criteria for emotional disturbance or mental illness.

Subd. 4. **Provider entity standards.** (a) A crisis intervention and crisis stabilization provider entity must meet the administrative and clinical standards specified in section 256B.0943, subdivisions 5 and 6, meet the standards listed in paragraph (b), and be:

(1) an Indian health service facility or facility owned and operated by a tribe or a tribal organization operating under Public Law 93-638 as a 638 facility;

(2) a county board-operated entity; or

(3) a provider entity that is under contract with the county board in the county where the potential crisis or emergency is occurring.

(b) The children's mental health crisis response services provider entity must:

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

(2) directly provide the services or, if services are subcontracted, the provider entity must maintain clinical responsibility for services and billing;

(3) ensure that crisis intervention services are provided in a manner consistent with sections 245.487 to 245.4889; and

(4) develop and maintain written policies and procedures regarding service provision that include safety of staff and recipients in high-risk situations.

Subd. 4a. **Alternative provider standards.** If a provider entity demonstrates that, due to geographic or other barriers, it is not feasible to provide mobile crisis intervention services 24 hours a day, seven days a week, according to the standards in subdivision 4, paragraph (b), clause (1), the commissioner may approve a crisis response provider based on an alternative plan proposed by a provider entity. The alternative plan must:

(1) result in increased access and a reduction in disparities in the availability of crisis services; and

(2) provide mobile services outside of the usual nine-to-five office hours and on weekends and holidays.

Subd. 5. **Mobile crisis intervention staff qualifications.** (a) To provide children's mental health mobile crisis intervention services, a mobile crisis intervention team must include:

(1) at least two mental health professionals as defined in section 256B.0943, subdivision 1, paragraph (o); or

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(2) a combination of at least one mental health professional and one mental health practitioner as defined in section 245.4871, subdivision 26, with the required mental health crisis training and under the clinical supervision of a mental health professional on the team.

(b) The team must have at least two people with at least one member providing on-site crisis intervention services when needed. Team members must be experienced in mental health assessment, crisis intervention techniques, and clinical decision making under emergency conditions and have knowledge of local services and resources. The team must recommend and coordinate the team's services with appropriate local resources, including the county social services agency, mental health service providers, and local law enforcement, if necessary.

Subd. 6. **Initial screening and crisis assessment planning.** (a) Before initiating mobile crisis intervention services, a screening of the potential crisis situation must be conducted. The screening may use the resources of crisis assistance and emergency services as defined in sections 245.4871, subdivision 14, and 245.4879, subdivisions 1 and 2. The screening must gather information, determine whether a crisis situation exists, identify the parties involved, and determine an appropriate response.

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

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

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

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

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

Subd. 7. **Crisis stabilization services.** Crisis stabilization services must be provided by a mental health professional or a mental health practitioner who works under the clinical supervision of a mental health professional and for a crisis stabilization services provider entity and must meet the following standards:

(1) a crisis stabilization treatment plan must be developed which meets the criteria in subdivision 8;

(2) services must be delivered according to the treatment plan and include face-to-face contact with the recipient by qualified staff for further assessment, help with referrals, updating the crisis stabilization

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treatment plan, supportive counseling, skills training, and collaboration with other service providers in the community; and

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

Subd. 8. **Treatment plan.** (a) The individual crisis stabilization treatment plan must include, at a minimum:

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

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

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

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

(5) documentation of the participants involved in the service planning;

(6) planned frequency and type of services initiated;

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

(8) clear progress notes on the outcome of goals.

(b) The client, if clinically appropriate, must be a participant in the development of the crisis stabilization treatment plan. The client or the client's legal guardian must sign the service plan or documentation must be provided why this was not possible. A copy of the plan must be given to the client and the client's legal guardian. The plan should include services arranged, including specific providers where applicable.

(c) A treatment plan must be developed by a mental health professional or mental health practitioner under the clinical supervision of a mental health professional. A written plan must be completed within 24 hours of beginning services with the client.

Subd. 9. **Supervision.** (a) A mental health practitioner may provide crisis assessment and mobile crisis intervention services if the following clinical supervision requirements are met:

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

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

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

(4) the mental health professional must review and approve the tentative crisis assessment and crisis treatment plan, document the consultation, and sign the crisis assessment and treatment plan within the next business day.

(b) If the mobile crisis intervention services continue into a second calendar day, a mental health professional must contact the client face-to-face on the second day to provide services and update the crisis

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treatment plan. The on-site observation must be documented in the client's record and signed by the mental health professional.

Subd. 10. **Client record.** The provider must maintain a file for each client that complies with the requirements under section 256B.0943, subdivision 11, and contains the following information:

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

(2) signed release of information forms;

(3) recipient health information and current medications;

(4) emergency contacts for the recipient;

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

(6) required clinical supervision by mental health professionals;

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

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

Subd. 11. **Excluded services.** The following services are excluded from reimbursement under this section:

(1) room and board services;

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

(3) transportation services under children's mental health crisis response service;

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

(5) crisis response services provided by a residential treatment center to clients in their facility;

(6) services performed by volunteers;

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

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

(9) outreach services to potential recipients; and

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

History: *1Sp2003 c 14 art 4 s 9; art 11 s 11; 2007 c 147 art 8 s 38; 2009 c 79 art 7 s 22; 2009 c 167 s 21; 2013 c 59 art 1 s 6*

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

Subdivision 1. **Residential services; provider qualifications.** (a) Counties must arrange to provide residential services for children with severe emotional disturbance according to sections 245.4882, 245.4885, and this section.

(b) 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.

(c) Eligible service costs may be claimed for a facility that is located in a state that borders Minnesota if:

(1) the facility is the closest facility to the child's home, providing the appropriate level of care; and

(2) the commissioner of human services has completed an inspection of the out-of-state program according to the interagency agreement with the commissioner of corrections under section 260B.198, subdivision 11, paragraph (b), and the program has been certified by the commissioner of corrections under section 260B.198, subdivision 11, paragraph (a), to substantially meet the standards applicable to children's residential mental health treatment programs under Minnesota Rules, chapter 2960. Nothing in this section requires the commissioner of human services to enforce the background study requirements under chapter 245C or the requirements related to prevention and investigation of alleged maltreatment under section 626.556 or 626.557. Complaints received by the commissioner of human services must be referred to the out-of-state licensing authority for possible follow-up.

(d) Notwithstanding paragraph (b), eligible service costs may be claimed for an out-of-state inpatient treatment facility if:

(1) the facility specializes in providing mental health services to children who are deaf, deafblind, or hard-of-hearing and who use American Sign Language as their first language;

(2) the facility is licensed by the state in which it is located; and

(3) the state in which the facility is located is a member state of the Interstate Compact on Mental Health.

Subd. 2. **Covered services.** All services must be included in a child's individualized treatment or multiagency plan of care as defined in chapter 245.

For facilities that are not institutions for mental diseases according to federal statute and regulation, 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 commissioner of management and budget.

Subd. 4. **Payment rates.** (a) Notwithstanding sections 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. Payment to counties for services provided according to this section shall be a proportion of the per day

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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) Per diem rates paid to providers under this section by prepaid plans shall be the proportion of the per-day contract rate that relates to rehabilitative mental health services and shall not include payment for group foster care costs or services that are billed to the county of financial responsibility. Services provided in facilities located in bordering states are eligible for reimbursement on a fee-for-service basis only as described in paragraph (a) and are not covered under prepaid health plans.

(c) Payment for mental health rehabilitative services provided under this section by or under contract with an American Indian tribe or tribal organization or by agencies operated by or under contract with an American Indian tribe or tribal organization must be made according to section 256B.0625, subdivision 34, or other relevant federally approved rate-setting methodology.

(d) The commissioner shall set aside a portion not to exceed five percent of the federal funds earned for county expenditures under this section to cover the state costs of 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. [Repealed, 2006 c 282 art 16 s 17]

Subd. 6. [Repealed, 2006 c 282 art 16 s 17]

Subd. 7. [Repealed, 2006 c 282 art 16 s 17]

Subd. 8. [Repealed, 2006 c 282 art 16 s 17]

Subd. 9. [Repealed, 2006 c 282 art 16 s 17]

Subd. 10. [Repealed, 1Sp2003 c 14 art 4 s 24]

History: *1999 c 245 art 8 s 9; 2000 c 340 s 4-11; 2002 c 277 s 19; 2003 c 112 art 2 s 50; 1Sp2003 c 14 art 4 s 10,11; art 11 s 11; 2006 c 282 art 16 s 7; 2007 c 147 art 8 s 23; 2009 c 101 art 2 s 109; 2009 c 174 art 1 s 5,6; 1Sp2011 c 9 art 8 s 7; 2012 c 148 s 1*

256B.0946 INTENSIVE TREATMENT IN FOSTER CARE.

Subdivision 1. **Required covered service components.** (a) Effective May 23, 2013, and subject to federal approval, medical assistance covers medically necessary intensive treatment services described under paragraph (b) that are provided by a provider entity eligible under subdivision 3 to a client eligible under subdivision 2 who is placed in a foster home licensed under Minnesota Rules, parts 2960.3000 to 2960.3340.

(b) Intensive treatment services to children with mental illness residing in foster family settings that comprise specific required service components provided in clauses (1) to (5) are reimbursed by medical assistance when they meet the following standards:

(1) psychotherapy provided by a mental health professional as defined in Minnesota Rules, part 9505.0371, subpart 5, item A, or a clinical trainee, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C;

(2) crisis assistance provided according to standards for children's therapeutic services and supports in section 256B.0943;

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(3) individual, family, and group psychoeducation services, defined in subdivision 1a, paragraph (q), provided by a mental health professional or a clinical trainee;

(4) clinical care consultation, as defined in subdivision 1a, and provided by a mental health professional or a clinical trainee; and

(5) service delivery payment requirements as provided under subdivision 4.

Subd. 1a. **Definitions.** For the purposes of this section, the following terms have the meanings given them.

(a) "Clinical care consultation" means communication from a treating clinician to other providers working with the same client to inform, inquire, and instruct regarding the client's symptoms, strategies for effective engagement, care and intervention needs, and treatment expectations across service settings, including but not limited to the client's school, social services, day care, probation, home, primary care, medication prescribers, disabilities services, and other mental health providers and to direct and coordinate clinical service components provided to the client and family.

(b) "Clinical supervision" means the documented time a clinical supervisor and supervisee spend together to discuss the supervisee's work, to review individual client cases, and for the supervisee's professional development. It includes the documented oversight and supervision responsibility for planning, implementation, and evaluation of services for a client's mental health treatment.

(c) "Clinical supervisor" means the mental health professional who is responsible for clinical supervision.

(d) "Clinical trainee" has the meaning given in Minnesota Rules, part 9505.0371, subpart 5, item C;

(e) "Crisis assistance" has the meaning given in section 245.4871, subdivision 9a, including the development of a plan that addresses prevention and intervention strategies to be used in a potential crisis, but does not include actual crisis intervention.

(f) "Culturally appropriate" means providing mental health services in a manner that incorporates the child's cultural influences, as defined in Minnesota Rules, part 9505.0370, subpart 9, into interventions as a way to maximize resiliency factors and utilize cultural strengths and resources to promote overall wellness.

(g) "Culture" means the distinct ways of living and understanding the world that are used by a group of people and are transmitted from one generation to another or adopted by an individual.

(h) "Diagnostic assessment" has the meaning given in Minnesota Rules, part 9505.0370, subpart 11.

(i) "Family" means a person who is identified by the client or the client's parent or guardian as being important to the client's mental health treatment. Family may include, but is not limited to, parents, foster parents, children, spouse, committed partners, former spouses, persons related by blood or adoption, persons who are a part of the client's permanency plan, or persons who are presently residing together as a family unit.

(j) "Foster care" has the meaning given in section 260C.007, subdivision 18.

(k) "Foster family setting" means the foster home in which the license holder resides.

(l) "Individual treatment plan" has the meaning given in Minnesota Rules, part 9505.0370, subpart 15.

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(m) "Mental health practitioner" has the meaning given in Minnesota Rules, part 9505.0370, subpart 17.

(n) "Mental health professional" has the meaning given in Minnesota Rules, part 9505.0370, subpart 18.

(o) "Mental illness" has the meaning given in Minnesota Rules, part 9505.0370, subpart 20.

(p) "Parent" has the meaning given in section 260C.007, subdivision 25.

(q) "Psychoeducation services" means information or demonstration provided to an individual, family, or group to explain, educate, and support the individual, family, or group in understanding a child's symptoms of mental illness, the impact on the child's development, and needed components of treatment and skill development so that the individual, family, or group can help the child to prevent relapse, prevent the acquisition of comorbid disorders, and achieve optimal mental health and long-term resilience.

(r) "Psychotherapy" has the meaning given in Minnesota Rules, part 9505.0370, subpart 27.

(s) "Team consultation and treatment planning" means the coordination of treatment plans and consultation among providers in a group concerning the treatment needs of the child, including disseminating the child's treatment service schedule to all members of the service team. Team members must include all mental health professionals working with the child, a parent, the child unless the team lead or parent deem it clinically inappropriate, and at least two of the following: an individualized education program case manager; probation agent; children's mental health case manager; child welfare worker, including adoption or guardianship worker; primary care provider; foster parent; and any other member of the child's service team.

Subd. 2. **Determination of client eligibility.** An eligible recipient is an individual, from birth through age 20, who is currently placed in a foster home licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, and has received a diagnostic assessment and an evaluation of level of care needed, as defined in paragraphs (a) and (b).

(a) The diagnostic assessment must:

(1) meet criteria described in Minnesota Rules, part 9505.0372, subpart 1, and be conducted by a mental health professional or a clinical trainee;

(2) determine whether or not a child meets the criteria for mental illness, as defined in Minnesota Rules, part 9505.0370, subpart 20;

(3) document that intensive treatment services are medically necessary within a foster family setting to ameliorate identified symptoms and functional impairments;

(4) be performed within 180 days before the start of service; and

(5) be completed as either a standard or extended diagnostic assessment annually to determine continued eligibility for the service.

(b) The evaluation of level of care must be conducted by the placing county, tribe, or case manager in conjunction with the diagnostic assessment as described by Minnesota Rules, part 9505.0372, subpart 1, item B, using a validated tool approved by the commissioner of human services and not subject to the rulemaking process, consistent with section 245.4885, subdivision 1, paragraph (d), the result of which evaluation

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demonstrates that the child requires intensive intervention without 24-hour medical monitoring. The commissioner shall update the list of approved level of care tools annually and publish on the department's Web site.

Subd. 3. **Eligible mental health services providers.** (a) Eligible providers for intensive children's mental health services in a foster family setting must be certified by the state and have a service provision contract with a county board or a reservation tribal council and must be able to demonstrate the ability to provide all of the services required in this section.

(b) For purposes of this section, a provider agency must be:

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

(2) an Indian Health Services facility operated by a tribe or tribal organization under funding authorized by United States Code, title 25, sections 450f to 450n, or title 3 of the Indian Self-Determination Act, Public Law 93-638, section 638 (facilities or providers); or

(3) a noncounty entity.

(c) Certified providers that do not meet the service delivery standards required in this section shall be subject to a decertification process.

(d) For the purposes of this section, all services delivered to a client must be provided by a mental health professional or a clinical trainee.

Subd. 4. **Service delivery payment requirements.** (a) To be eligible for payment under this section, a provider must develop and practice written policies and procedures for intensive treatment in foster care, consistent with subdivision 1, paragraph (b), and comply with the following requirements in paragraphs (b) to (n).

(b) A qualified clinical supervisor, as defined in and performing in compliance with Minnesota Rules, part 9505.0371, subpart 5, item D, must supervise the treatment and provision of services described in this section.

(c) Each client receiving treatment services must receive an extended diagnostic assessment, as described in Minnesota Rules, part 9505.0372, subpart 1, item C, within 30 days of enrollment in this service unless the client has a previous extended diagnostic assessment that the client, parent, and mental health professional agree still accurately describes the client's current mental health functioning.

(d) Each previous and current mental health, school, and physical health treatment provider must be contacted to request documentation of treatment and assessments that the eligible client has received. This information must be reviewed and incorporated into the diagnostic assessment and team consultation and treatment planning review process.

(e) Each client receiving treatment must be assessed for a trauma history, and the client's treatment plan must document how the results of the assessment will be incorporated into treatment.

(f) Each client receiving treatment services must have an individual treatment plan that is reviewed, evaluated, and signed every 90 days using the team consultation and treatment planning process, as defined in subdivision 1a, paragraph (s).

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(g) Care consultation, as defined in subdivision 1a, paragraph (a), must be provided in accordance with the client's individual treatment plan.

(h) Each client must have a crisis assistance plan within ten days of initiating services and must have access to clinical phone support 24 hours per day, seven days per week, during the course of treatment. The crisis plan must demonstrate coordination with the local or regional mobile crisis intervention team.

(i) Services must be delivered and documented at least three days per week, equaling at least six hours of treatment per week, unless reduced units of service are specified on the treatment plan as part of transition or on a discharge plan to another service or level of care. Documentation must comply with Minnesota Rules, parts 9505.2175 and 9505.2197.

(j) Location of service delivery must be in the client's home, day care setting, school, or other community-based setting that is specified on the client's individualized treatment plan.

(k) Treatment must be developmentally and culturally appropriate for the client.

(l) Services must be delivered in continual collaboration and consultation with the client's medical providers and, in particular, with prescribers of psychotropic medications, including those prescribed on an off-label basis. Members of the service team must be aware of the medication regimen and potential side effects.

(m) Parents, siblings, foster parents, and members of the child's permanency plan must be involved in treatment and service delivery unless otherwise noted in the treatment plan.

(n) Transition planning for the child must be conducted starting with the first treatment plan and must be addressed throughout treatment to support the child's permanency plan and postdischarge mental health service needs.

Subd. 5. **Service authorization.** The commissioner will administer authorizations for services under this section in compliance with section 256B.0625, subdivision 25.

Subd. 6. **Excluded services.** (a) Services in clauses (1) to (7) are not covered under this section and are not eligible for medical assistance payment as components of intensive treatment in foster care services, but may be billed separately:

(1) inpatient psychiatric hospital treatment;

(2) mental health targeted case management;

(3) partial hospitalization;

(4) medication management;

(5) children's mental health day treatment services;

(6) crisis response services under section 256B.0944; and

(7) transportation.

(b) Children receiving intensive treatment in foster care services are not eligible for medical assistance reimbursement for the following services while receiving intensive treatment in foster care:

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(1) psychotherapy and skills training components of children's therapeutic services and supports under section 256B.0625, subdivision 35b;

(2) mental health behavioral aide services as defined in section 256B.0943, subdivision 1, paragraph (m);

(3) home and community-based waiver services;

(4) mental health residential treatment; and

(5) room and board costs as defined in section 256I.03, subdivision 6.

Subd. 7. **Medical assistance payment and rate setting.** The commissioner shall establish a single daily per-client encounter rate for intensive treatment in foster care services. The rate must be constructed to cover only eligible services delivered to an eligible recipient by an eligible provider, as prescribed in subdivision 1, paragraph (b).

History: *1Sp2005 c 4 art 2 s 12; 2006 c 282 art 16 s 8; 2007 c 147 art 8 s 38; 2013 c 108 art 4 s 26*

256B.0947 INTENSIVE REHABILITATIVE MENTAL HEALTH SERVICES.

Subdivision 1. **Scope.** Effective November 1, 2011, and subject to federal approval, medical assistance covers medically necessary, intensive nonresidential rehabilitative mental health services as defined in subdivision 2, for recipients as defined in subdivision 3, when the services are provided by an entity meeting the standards in this section.

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

(a) "Intensive nonresidential rehabilitative mental health services" means child rehabilitative mental health services as defined in section 256B.0943, except that these services are provided by a multidisciplinary staff using a total team approach consistent with assertive community treatment, as adapted for youth, and are directed to recipients ages 16 to 21 with a serious mental illness or co-occurring mental illness and substance abuse addiction who require intensive services to prevent admission to an inpatient psychiatric hospital or placement in a residential treatment facility or who require intensive services to step down from inpatient or residential care to community-based care.

(b) "Co-occurring mental illness and substance abuse addiction" means a dual diagnosis of at least one form of mental illness and at least one substance use disorder. Substance use disorders include alcohol or drug abuse or dependence, excluding nicotine use.

(c) "Diagnostic assessment" has the meaning given to it in Minnesota Rules, part 9505.0370, subpart 11. A diagnostic assessment must be provided according to Minnesota Rules, part 9505.0372, subpart 1, and for this section must incorporate a determination of the youth's necessary level of care using a standardized functional assessment instrument approved and periodically updated by the commissioner.

(d) "Education specialist" means an individual with knowledge and experience working with youth regarding special education requirements and goals, special education plans, and coordination of educational activities with health care activities.

(e) "Housing access support" means an ancillary activity to help an individual find, obtain, retain, and move to safe and adequate housing. Housing access support does not provide monetary assistance for rent, damage deposits, or application fees.

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(f) "Integrated dual disorders treatment" means the integrated treatment of co-occurring mental illness and substance use disorders by a team of cross-trained clinicians within the same program, and is characterized by assertive outreach, stage-wise comprehensive treatment, treatment goal setting, and flexibility to work within each stage of treatment.

(g) "Medication education services" means services provided individually or in groups, which focus on:

(1) educating the client and client's family or significant nonfamilial supporters about mental illness and symptoms;

(2) the role and effects of medications in treating symptoms of mental illness; and

(3) the side effects of medications.

Medication education is coordinated with medication management services and does not duplicate it. Medication education services are provided by physicians, pharmacists, or registered nurses with certification in psychiatric and mental health care.

(h) "Peer specialist" means an employed team member who is a certified peer specialist and also a former children's mental health consumer who:

(1) provides direct services to clients including social, emotional, and instrumental support and outreach;

(2) assists younger peers to identify and achieve specific life goals;

(3) works directly with clients to promote the client's self-determination, personal responsibility, and empowerment;

(4) assists youth with mental illness to regain control over their lives and their developmental process in order to move effectively into adulthood;

(5) provides training and education to other team members, consumer advocacy organizations, and clients on resiliency and peer support; and

(6) meets the following criteria:

(i) is at least 22 years of age;

(ii) has had a diagnosis of mental illness, as defined in Minnesota Rules, part 9505.0370, subpart 20, or co-occurring mental illness and substance abuse addiction;

(iii) is a former consumer of child and adolescent mental health services, or a former or current consumer of adult mental health services for a period of at least two years;

(iv) has at least a high school diploma or equivalent;

(v) has successfully completed training requirements determined and periodically updated by the commissioner;

(vi) is willing to disclose the individual's own mental health history to team members and clients; and

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(vii) must be free of substance use problems for at least one year.

(i) "Provider agency" means a for-profit or nonprofit organization established to administer an assertive community treatment for youth team.

(j) "Substance use disorders" means one or more of the disorders defined in the diagnostic and statistical manual of mental disorders, current edition.

(k) "Transition services" means:

(1) activities, materials, consultation, and coordination that ensures continuity of the client's care in advance of and in preparation for the client's move from one stage of care or life to another by maintaining contact with the client and assisting the client to establish provider relationships;

(2) providing the client with knowledge and skills needed posttransition;

(3) establishing communication between sending and receiving entities;

(4) supporting a client's request for service authorization and enrollment; and

(5) establishing and enforcing procedures and schedules.

A youth's transition from the children's mental health system and services to the adult mental health system and services and return to the client's home and entry or re-entry into community-based mental health services following discharge from an out-of-home placement or inpatient hospital stay.

(l) "Treatment team" means all staff who provide services to recipients under this section.

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

(1) is age 16, 17, 18, 19, or 20; and

(2) is diagnosed with a serious mental illness or co-occurring mental illness and substance abuse addiction, for which intensive nonresidential rehabilitative mental health services are needed;

(3) has received a level-of-care determination, using an instrument approved by the commissioner, that indicates a need for intensive integrated intervention without 24-hour medical monitoring and a need for extensive collaboration among multiple providers;

(4) has a functional impairment and a history of difficulty in functioning safely and successfully in the community, school, home, or job; or who is likely to need services from the adult mental health system within the next two years; and

(5) has had a recent diagnostic assessment, as provided in Minnesota Rules, part 9505.0372, subpart 1, by a mental health professional who is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A, that documents that intensive nonresidential rehabilitative mental health services are medically necessary to ameliorate identified symptoms and functional impairments and to achieve individual transition goals.

Subd. 3a. **Required service components.** (a) Subject to federal approval, medical assistance covers all medically necessary intensive nonresidential rehabilitative mental health services and supports, as defined

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in this section, under a single daily rate per client. Services and supports must be delivered by an eligible provider under subdivision 5 to an eligible client under subdivision 3.

(b) Intensive nonresidential rehabilitative mental health services, supports, and ancillary activities covered by the single daily rate per client must include the following, as needed by the individual client:

(1) individual, family, and group psychotherapy;

(2) individual, family, and group skills training, as defined in section 256B.0943, subdivision 1, paragraph (q);

(3) crisis assistance as defined in section 245.4871, subdivision 9a, which includes recognition of factors precipitating a mental health crisis, identification of behaviors related to the crisis, and the development of a plan to address prevention, intervention, and follow-up strategies to be used in the lead-up to or onset of, and conclusion of, a mental health crisis; crisis assistance does not mean crisis response services or crisis intervention services provided in section 256B.0944;

(4) medication management provided by a physician or an advanced practice registered nurse with certification in psychiatric and mental health care;

(5) mental health case management as provided in section 256B.0625, subdivision 20;

(6) medication education services as defined in this section;

(7) care coordination by a client-specific lead worker assigned by and responsible to the treatment team;

(8) psychoeducation of and consultation and coordination with the client's biological, adoptive, or foster family and, in the case of a youth living independently, the client's immediate nonfamilial support network;

(9) clinical consultation to a client's employer or school or to other service agencies or to the courts to assist in managing the mental illness or co-occurring disorder and to develop client support systems;

(10) coordination with, or performance of, crisis intervention and stabilization services as defined in section 256B.0944;

(11) assessment of a client's treatment progress and effectiveness of services using standardized outcome measures published by the commissioner;

(12) transition services as defined in this section;

(13) integrated dual disorders treatment as defined in this section; and

(14) housing access support.

(c) The provider shall ensure and document the following by means of performing the required function or by contracting with a qualified person or entity:

(1) client access to crisis intervention services, as defined in section 256B.0944, and available 24 hours per day and seven days per week;

(2) completion of an extended diagnostic assessment, as defined in Minnesota Rules, part 9505.0372, subpart 1, item C; and

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(3) determination of the client's needed level of care using an instrument approved and periodically updated by the commissioner.

Subd. 4. **Provider contract requirements.** (a) The intensive nonresidential rehabilitative mental health services provider agency shall have a contract with the commissioner to provide intensive transition youth rehabilitative mental health services.

(b) The commissioner shall develop administrative and clinical contract standards and performance evaluation criteria for providers, including county providers, and may require applicants to submit documentation as needed to allow the commissioner to determine whether the standards are met.

Subd. 5. **Standards for intensive nonresidential rehabilitative providers.** (a) Services must be provided by a provider entity as provided in subdivision 4.

(b) The treatment team for intensive nonresidential rehabilitative mental health services comprises both permanently employed core team members and client-specific team members as follows:

(1) The core treatment team is an entity that operates under the direction of an independently licensed mental health professional, who is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A, and that assumes comprehensive clinical responsibility for clients. Based on professional qualifications and client needs, clinically qualified core team members are assigned on a rotating basis as the client's lead worker to coordinate a client's care. The core team must comprise at least four full-time equivalent direct care staff and must include, but is not limited to:

(i) an independently licensed mental health professional, qualified under Minnesota Rules, part 9505.0371, subpart 5, item A, who serves as team leader to provide administrative direction and clinical supervision to the team;

(ii) an advanced-practice registered nurse with certification in psychiatric or mental health care or a board-certified child and adolescent psychiatrist, either of which must be credentialed to prescribe medications;

(iii) a licensed alcohol and drug counselor who is also trained in mental health interventions; and

(iv) a peer specialist as defined in subdivision 2, paragraph (h).

(2) The core team may also include any of the following:

(i) additional mental health professionals;

(ii) a vocational specialist;

(iii) an educational specialist;

(iv) a child and adolescent psychiatrist who may be retained on a consultant basis;

(v) a mental health practitioner, as defined in section 245.4871, subdivision 26;

(vi) a mental health manager, as defined in section 245.4871, subdivision 4; and

(vii) a housing access specialist.

(3) A treatment team may include, in addition to those in clause (1) or (2), ad hoc members not employed by the team who consult on a specific client and who must accept overall clinical direction from the treatment

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team for the duration of the client's placement with the treatment team and must be paid by the provider agency at the rate for a typical session by that provider with that client or at a rate negotiated with the client-specific member. Client-specific treatment team members may include:

(i) the mental health professional treating the client prior to placement with the treatment team;

(ii) the client's current substance abuse counselor, if applicable;

(iii) a lead member of the client's individualized education program team or school-based mental health provider, if applicable;

(iv) a representative from the client's health care home or primary care clinic, as needed to ensure integration of medical and behavioral health care;

(v) the client's probation officer or other juvenile justice representative, if applicable; and

(vi) the client's current vocational or employment counselor, if applicable.

(c) The clinical supervisor shall be an active member of the treatment team and shall function as a practicing clinician at least on a part-time basis. The treatment team shall meet with the clinical supervisor at least weekly to discuss recipients' progress and make rapid adjustments to meet recipients' needs. The team meeting must include client-specific case reviews and general treatment discussions among team members. Client-specific case reviews and planning must be documented in the individual client's treatment record.

(d) The staffing ratio must not exceed ten clients to one full-time equivalent treatment team position.

(e) The treatment team shall serve no more than 80 clients at any one time. Should local demand exceed the team's capacity, an additional team must be established rather than exceed this limit.

(f) Nonclinical staff shall have prompt access in person or by telephone to a mental health practitioner or mental health professional. The provider shall have the capacity to promptly and appropriately respond to emergent needs and make any necessary staffing adjustments to assure the health and safety of clients.

(g) The intensive nonresidential rehabilitative mental health services provider shall participate in evaluation of the assertive community treatment for youth (Youth ACT) model as conducted by the commissioner, including the collection and reporting of data and the reporting of performance measures as specified by contract with the commissioner.

(h) A regional treatment team may serve multiple counties.

Subd. 6. **Service standards.** The standards in this subdivision apply to intensive nonresidential rehabilitative mental health services.

(a) The treatment team shall use team treatment, not an individual treatment model.

(b) Services must be available at times that meet client needs.

(c) The initial functional assessment must be completed within ten days of intake and updated at least every three months or prior to discharge from the service, whichever comes first.

(d) An individual treatment plan must be completed for each client, according to criteria specified in section 256B.0943, subdivision 6, paragraph (b), clause (2), and, additionally, must:

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(1) be completed in consultation with the client's current therapist and key providers and provide for ongoing consultation with the client's current therapist to ensure therapeutic continuity and to facilitate the client's return to the community;

(2) if a need for substance use disorder treatment is indicated by validated assessment:

(i) identify goals, objectives, and strategies of substance use disorder treatment; develop a schedule for accomplishing treatment goals and objectives; and identify the individuals responsible for providing treatment services and supports;

(ii) be reviewed at least once every 90 days and revised, if necessary;

(3) be signed by the clinical supervisor and by the client and, if the client is a minor, by the client's parent or other person authorized by statute to consent to mental health treatment and substance use disorder treatment for the client; and

(4) provide for the client's transition out of intensive nonresidential rehabilitative mental health services by defining the team's actions to assist the client and subsequent providers in the transition to less intensive or "stepped down" services.

(e) The treatment team shall actively and assertively engage the client's family members and significant others by establishing communication and collaboration with the family and significant others and educating the family and significant others about the client's mental illness, symptom management, and the family's role in treatment, unless the team knows or has reason to suspect that the client has suffered or faces a threat of suffering any physical or mental injury, abuse, or neglect from a family member or significant other.

(f) For a client age 18 or older, the treatment team may disclose to a family member, other relative, or a close personal friend of the client, or other person identified by the client, the protected health information directly relevant to such person's involvement with the client's care, as provided in Code of Federal Regulations, title 45, part 164.502(b). If the client is present, the treatment team shall obtain the client's agreement, provide the client with an opportunity to object, or reasonably infer from the circumstances, based on the exercise of professional judgment, that the client does not object. If the client is not present or is unable, by incapacity or emergency circumstances, to agree or object, the treatment team may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of the client and, if so, disclose only the protected health information that is directly relevant to the family member's, relative's, friend's, or client-identified person's involvement with the client's health care. The client may orally agree or object to the disclosure and may prohibit or restrict disclosure to specific individuals.

(g) The treatment team shall provide interventions to promote positive interpersonal relationships.

Subd. 7. **Medical assistance payment and rate setting.** (a) Payment for services in this section must be based on one daily encounter rate per provider inclusive of the following services received by an eligible client in a given calendar day: all rehabilitative services, supports, and ancillary activities under this section, staff travel time to provide rehabilitative services under this section, and crisis response services under section 256B.0944.

(b) Payment must not be made to more than one entity for each client for services provided under this section on a given day. If services under this section are provided by a team that includes staff from more than one entity, the team shall determine how to distribute the payment among the members.

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(c) The commissioner shall establish regional cost-based rates for entities that will bill medical assistance for nonresidential intensive rehabilitative mental health services. In developing these rates, the commissioner shall consider:

(1) the cost for similar services in the health care trade area;

(2) actual costs incurred by entities providing the services;

(3) the intensity and frequency of services to be provided to each client;

(4) the degree to which clients will receive services other than services under this section; and

(5) the costs of other services that will be separately reimbursed.

(d) The rate for a provider must not exceed the rate charged by that provider for the same service to other payers.

Subd. 7a. **Noncovered services.** (a) The rate for intensive rehabilitative mental health services must exclude medical assistance payment for services not covered under this section. Services not covered under this section may be billed separately.

(b) The following services are not covered under this section and are not eligible for medical assistance payment under the per-client, per-day payment:

(1) inpatient psychiatric hospital treatment;

(2) mental health residential treatment;

(3) partial hospitalization;

(4) physician services outside of care provided by a psychiatrist serving as a member of the treatment team;

(5) room and board costs, as defined in section 256I.03, subdivision 6;

(6) children's mental health day treatment services; and

(7) mental health behavioral aide services, as defined in section 256B.0943, subdivision 1, paragraph (m).

Subd. 8. **Provider enrollment.** The commissioner shall establish and administer treatment teams with consideration given to regional distribution. Providers shall apply directly to the commissioner for enrollment and must be reimbursed at rates established by contract. The commissioner shall perform the program review.

Subd. 9. **Service authorization.** The commissioner shall publish prior authorization criteria and standards to be used for intensive nonresidential rehabilitative mental health services, as provided in section 256B.0625, subdivision 25.

History: *1Sp2005 c 4 art 2 s 13; 2009 c 79 art 7 s 23; 2010 c 200 art 1 s 7; 2011 c 86 s 20; 1Sp2011 c 11 art 3 s 12; 2014 c 275 art 1 s 62*

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256B.0948 FOSTER CARE RATE LIMITS.

The commissioner shall decrease by five percent rates for adult foster care and supportive living services that are reimbursed under section 256B.092 or 256B.49, and are above the 95th percentile of the statewide rates for the service. The reduction in rates shall take into account the acuity of individuals served based on the methodology used to allocate dollars to local lead agency budgets, and assure that affected service rates are not reduced below the rate level represented by the above percentile due to this rate change. Lead agency contracts for services specified in this section shall be amended to implement these rate changes for services rendered on or after July 1, 2009. The commissioner shall make corresponding reductions to waiver allocations and capitated rates.

History: *2009 c 79 art 8 s 55*

256B.0949 AUTISM EARLY INTENSIVE INTERVENTION BENEFIT.

Subdivision 1. **Purpose.** This section creates a new benefit to provide early intensive intervention to a child with an autism spectrum disorder diagnosis. This benefit must provide coverage for diagnosis, multidisciplinary assessment, ongoing progress evaluation, and medically necessary treatment of autism spectrum disorder.

[See Note.]

Subd. 2. **Definitions.** (a) For the purposes of this section, the terms defined in this subdivision have the meanings given.

(b) "Autism spectrum disorder diagnosis" is defined by diagnostic code 299 in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

(c) "Child" means a person under the age of 18.

(d) "Commissioner" means the commissioner of human services, unless otherwise specified.

(e) "Early intensive intervention benefit" means autism treatment options based in behavioral and developmental science, which may include modalities such as applied behavior analysis, developmental treatment approaches, and naturalistic and parent training models.

(f) "Generalizable goals" means results or gains that are observed during a variety of activities with different people, such as providers, family members, other adults, and children, and in different environments including, but not limited to, clinics, homes, schools, and the community.

(g) "Mental health professional" has the meaning given in section 245.4871, subdivision 27, clauses (1) to (6).

[See Note.]

Subd. 3. **Initial eligibility.** This benefit is available to a child enrolled in medical assistance who:

(1) has an autism spectrum disorder diagnosis;

(2) has had a diagnostic assessment described in subdivision 5, which recommends early intensive intervention services; and

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(3) meets the criteria for medically necessary autism early intensive intervention services.

[See Note.]

Subd. 4. **Diagnosis.** (a) A diagnosis must:

(1) be based upon current DSM criteria including direct observations of the child and reports from parents or primary caregivers; and

(2) be completed by either (i) a licensed physician or advanced practice registered nurse or (ii) a mental health professional.

(b) Additional diagnostic assessment information may be considered including from special education evaluations and licensed school personnel, and from professionals licensed in the fields of medicine, speech and language, psychology, occupational therapy, and physical therapy.

[See Note.]

Subd. 5. **Diagnostic assessment.** The following information and assessments must be performed, reviewed, and relied upon for the eligibility determination, treatment and services recommendations, and treatment plan development for the child:

(1) an assessment of the child's developmental skills, functional behavior, needs, and capacities based on direct observation of the child which must be administered by a licensed mental health professional, must include medical or assessment information from the child's physician or advanced practice registered nurse, and may also include observations from family members, school personnel, child care providers, or other caregivers, as well as any medical or assessment information from other licensed professionals such as rehabilitation therapists, licensed school personnel, or mental health professionals; and

(2) an assessment of parental or caregiver capacity to participate in therapy including the type and level of parental or caregiver involvement and training recommended.

[See Note.]

Subd. 6. **Treatment plan.** (a) Each child's treatment plan must be:

(1) based on the diagnostic assessment information specified in subdivisions 4 and 5;

(2) coordinated with medically necessary occupational, physical, and speech and language therapies, special education, and other services the child and family are receiving;

(3) family-centered;

(4) culturally sensitive; and

(5) individualized based on the child's developmental status and the child's and family's identified needs.

(b) The treatment plan must specify the:

(1) child's goals which are developmentally appropriate, functional, and generalizable;

(2) treatment modality;

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(3) treatment intensity;

(4) setting; and

(5) level and type of parental or caregiver involvement.

(c) The treatment must be supervised by a professional with expertise and training in autism and child development who is a licensed physician, advanced practice registered nurse, or mental health professional.

(d) The treatment plan must be submitted to the commissioner for approval in a manner determined by the commissioner for this purpose.

(e) Services authorized must be consistent with the child's approved treatment plan.

Services included in the treatment plan must meet all applicable requirements for medical necessity and coverage.

[See Note.]

Subd. 7. **Ongoing eligibility.** (a) An independent progress evaluation conducted by a licensed mental health professional with expertise and training in autism spectrum disorder and child development must be completed after each six months of treatment, or more frequently as determined by the commissioner, to determine if progress is being made toward achieving generalizable goals and meeting functional goals contained in the treatment plan.

(b) The progress evaluation must include:

(1) the treating provider's report;

(2) parental or caregiver input;

(3) an independent observation of the child which can be performed by the child's licensed special education staff;

(4) any treatment plan modifications; and

(5) recommendations for continued treatment services.

(c) Progress evaluations must be submitted to the commissioner in a manner determined by the commissioner for this purpose.

(d) A child who continues to achieve generalizable goals and treatment goals as specified in the treatment plan is eligible to continue receiving this benefit.

(e) A child's treatment shall continue during the progress evaluation using the process determined under subdivision 8, clause (8). Treatment may continue during an appeal pursuant to section 256.045.

[See Note.]

Subd. 8. **Refining the benefit with stakeholders.** The commissioner must develop the implementation details of the benefit in consultation with stakeholders and consider recommendations from the Health Services Advisory Council, the Department of Human Services Autism Spectrum Disorder Advisory Council, the Legislative Autism Spectrum Disorder Task Force, and the Interagency Task Force of the De-

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partments of Health, Education, and Human Services. The commissioner must release these details for a 30-day public comment period prior to submission to the federal government for approval. The implementation details must include, but are not limited to, the following components:

(1) a definition of the qualifications, standards, and roles of the treatment team, including recommendations after stakeholder consultation on whether board-certified behavior analysts and other types of professionals trained in autism spectrum disorder and child development should be added as mental health or other professionals for treatment supervision or other functions under medical assistance;

(2) development of initial, uniform parameters for comprehensive multidisciplinary diagnostic assessment information and progress evaluation standards;

(3) the design of an effective and consistent process for assessing parent and caregiver capacity to participate in the child's early intervention treatment and methods of involving the parents and caregivers in the treatment of the child;

(4) formulation of a collaborative process in which professionals have opportunities to collectively inform a comprehensive, multidisciplinary diagnostic assessment and progress evaluation processes and standards to support quality improvement of early intensive intervention services;

(5) coordination of this benefit and its interaction with other services provided by the Departments of Human Services, Health, and Education;

(6) evaluation, on an ongoing basis, of research regarding the program and treatment modalities provided to children under this benefit;

(7) determination of the availability of licensed physicians, nurse practitioners, and mental health professionals with expertise and training in autism spectrum disorder throughout the state to assess whether there are sufficient professionals to require involvement of both a physician or nurse practitioner and a mental health professional to provide access and prevent delay in the diagnosis and treatment of young children, so as to implement subdivision 4, and to ensure treatment is effective, timely, and accessible; and

(8) development of the process for the progress evaluation that will be used to determine the ongoing eligibility, including necessary documentation, timelines, and responsibilities of all parties.

Subd. 9. **Revision of treatment options.** (a) The commissioner may revise covered treatment options as needed based on outcome data and other evidence.

(b) Before the changes become effective, the commissioner must provide public notice of the changes, the reasons for the change, and a 30-day public comment period to those who request notice through an electronic list accessible to the public on the department's Web site.

[See Note.]

Subd. 10. **Coordination between agencies.** The commissioners of human services and education must develop the capacity to coordinate services and information including diagnostic, functional, developmental, medical, and educational assessments; service delivery; and progress evaluations across health and education sectors.

Subd. 11. **Federal approval of the autism benefit.** (a) This section shall apply to state plan services under title XIX of the Social Security Act when federal approval is granted under a 1915(i) waiver or other

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authority which allows children eligible for medical assistance through the TEFRA option under section 256B.055, subdivision 12, to qualify and includes children eligible for medical assistance in families over 150 percent of the federal poverty guidelines.

(b) The commissioner may use the federal authority for a Medicaid state plan amendment under Early and Periodic Screening Diagnosis and Treatment (EPSDT), United States Code, title 42, section 1396D(R)(5), or other Medicaid provision for any aspect or type of treatment covered in this section if new federal guidance is helpful in achieving one or more of the purposes of this section in a cost-effective manner. Notwithstanding subdivisions 2 and 3, any treatment services submitted for federal approval under EPSDT shall include appropriate medical criteria to qualify for the service and shall cover children through age 20.

Subd. 12. **Autism benefit; training provided.** After approval of the autism early intensive intervention benefit under this section by the Centers for Medicare and Medicaid Services, the commissioner shall provide statewide training on the benefit for culturally and linguistically diverse communities. Training for autism service providers on culturally appropriate practices must be online, accessible, and available in multiple languages. The training for families, lead agencies, advocates, and other interested parties must provide information about the benefit and how to access it.

History: *2013 c 108 art 7 s 14; 2014 c 275 art 1 s 63,140; 2014 c 312 art 27 s 52-55*

NOTE: Subdivisions 1 to 7 and 9, as added by Laws 2013, chapter 108, article 7, section 14, are effective upon federal approval consistent with subdivision 11, but no earlier than July 1, 2014. Laws 2013, chapter 108, article 7, section 14, the effective date, as amended by Laws 2014, chapter 312, article 27, section 73.

QUALITY ASSURANCE

256B.095 QUALITY ASSURANCE SYSTEM ESTABLISHED.

(a) Effective July 1, 1998, a quality assurance system for persons with developmental disabilities, which includes an alternative quality assurance licensing system for programs, is established in Dodge, Fillmore, Freeborn, Goodhue, Houston, Mower, Olmsted, Rice, Steele, Wabasha, and Winona Counties for the purpose of improving the quality of services provided to persons with developmental disabilities. A county, at its option, may choose to have all programs for persons with developmental disabilities located within the county licensed under chapter 245A using standards determined under the alternative quality assurance licensing system or may continue regulation of these programs under the licensing system operated by the commissioner.

(b) Effective July 1, 2003, a county not listed in paragraph (a) may apply to participate in the quality assurance system established under paragraph (a). The commission established under section 256B.0951 may, at its option, allow additional counties to participate in the system.

(c) Effective July 1, 2003, any county or group of counties not listed in paragraph (a) may establish a quality assurance system under this section. A new system established under this section shall have the same rights and duties as the system established under paragraph (a). A new system shall be governed by a commission under section 256B.0951. The commissioner shall appoint the initial commission members based on recommendations from advocates, families, service providers, and counties in the geographic area included in the new system. Counties that choose to participate in a new system shall have the duties assigned under section 256B.0952. The new system shall establish a quality assurance process under section 256B.0953. The provisions of section 256B.0954 shall apply to a new system established under

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this paragraph. The commissioner shall delegate authority to a new system established under this paragraph according to section 256B.0955.

(d) Effective July 1, 2007, the quality assurance system may be expanded to include programs for persons with disabilities and older adults.

(e) Effective July 1, 2013, a provider of service located in a county listed in paragraph (a) that is a non-opted-in county may opt in to the quality assurance system provided the county where services are provided indicates its agreement with a county with a delegation agreement with the Department of Human Services.

History: *1997 c 203 art 7 s 18; 1Sp2001 c 9 art 3 s 48; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 3 s 33; 1Sp2005 c 4 art 7 s 24; 2007 c 147 art 7 s 16; 2013 c 108 art 7 s 15*

256B.0951 QUALITY ASSURANCE COMMISSION.

Subdivision 1. **Membership.** The 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. 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.

Subd. 2. **Authority to hire staff; charge fees; provide technical assistance.** (a) The commission may hire staff to perform the duties assigned in this section.

(b) The commission may charge fees for its services.

(c) The commission may provide technical assistance to other counties, families, providers, and advocates interested in participating in a quality assurance system under section 256B.095, paragraph (b) or (c).

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.

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(d) The commission, in consultation with the commissioner, shall work cooperatively with other populations to expand the system to those populations and identify barriers to expansion. The commissioner shall report findings and recommendations to the legislature by December 15, 2004.

Subd. 4. **Commission's authority to recommend variances of licensing standards.** The commission may recommend to the commissioners of human services and health variances from the standards governing licensure of programs for persons with disabilities in order to improve the quality of services by implementing an alternative disabilities licensing system if the commission determines that the alternative licensing system does not adversely affect the health or safety of persons being served by the licensed program nor compromise the qualifications of staff to provide services.

Subd. 5. **Variance of certain standards prohibited.** The safety standards, rights, or procedural protections under chapter 245C and sections 245.825; 245.91 to 245.97; 245A.09, subdivision 2, paragraph (c), clauses (2) and (5); 245A.12; 245A.13; 252.41, subdivision 9; 256B.092, subdivisions 1b, clause (7), and 10; 626.556; 626.557, and procedures for the monitoring of psychotropic medications shall not be varied under the alternative quality assurance licensing system. The commission may make recommendations to the commissioners of human services and health or to the legislature regarding alternatives to or modifications of the rules and procedures referenced in this subdivision.

Subd. 6. [Repealed, 1Sp2001 c 9 art 3 s 76]

Subd. 7. **Waiver of rules.** If a federal waiver is approved under subdivision 8, the commissioner of health may exempt residents of intermediate care facilities for persons with developmental disabilities (ICFs/DD) who participate in the alternative quality assurance system established in section 256B.095 from the requirements of Minnesota Rules, chapter 4665.

Subd. 8. **Federal waiver.** The commissioner of human services shall seek a federal waiver to allow intermediate care facilities for persons with developmental disabilities (ICFs/DD) in region 10 of Minnesota to participate in the alternative licensing system. If it is necessary for purposes of participation in this alternative licensing system for a facility to be decertified as an ICF/DD facility according to the terms of the federal waiver, when the facility seeks recertification under the provisions of ICF/DD regulations at the end of the demonstration project, it will not be considered a new ICF/DD as defined under section 252.291 provided the licensed capacity of the facility did not increase during its participation in the alternative licensing system. The provisions of sections 252.28, 252.292, and 256B.5011 to 256B.5015 will remain applicable for counties in region 10 of Minnesota and the ICFs/DD located within those counties notwithstanding a county's participation in the alternative licensing system.

Subd. 9. **Evaluation.** The commission, in consultation with the commissioner of human services, shall conduct an evaluation of the quality assurance system, and present a report to the commissioner by June 30, 2004.

History: *1997 c 203 art 7 s 19; 1998 c 407 art 4 s 40; 1999 c 245 art 4 s 63,64; 1Sp2001 c 9 art 3 s 49-55; 2002 c 375 art 2 s 32,33; 2002 c 379 art 1 s 113; 2003 c 15 art 1 s 33; 1Sp2003 c 14 art 3 s 34-39; 2005 c 10 art 1 s 53; 2005 c 56 s 1; 1Sp2005 c 4 art 7 s 25; 2007 c 147 art 7 s 17; 2013 c 108 art 7 s 16,17; 2013 c 125 art 1 s 107*

256B.0952 COUNTY DUTIES; QUALITY ASSURANCE TEAMS.

Subdivision 1. **Notification.** Counties or providers shall give notice to the commission and commissioners of human services and health of intent to join the alternative quality assurance licensing system.

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A county or provider choosing to participate in the alternative quality assurance licensing system commits to participate for three years.

Subd. 2. **Appointment of review council; duties of council.** A county or group of counties that chooses to participate in the alternative licensing system shall appoint a quality assurance review council comprised of advocates; consumers, families, and their legal representatives; providers; and county staff. The council shall:

(1) review summary reports from quality assurance team reviews and make recommendations to counties regarding program licensure;

(2) make recommendations to the commission regarding the alternative licensing system and quality assurance process; and

(3) resolve complaints between the quality assurance teams, counties, providers, and consumers, families, and their legal representatives.

Subd. 3. **Notice to commissioners.** The county, based on reports from quality assurance managers and recommendations from the quality assurance review council regarding the findings of quality assurance teams, shall notify the commissioners of human services and health regarding whether facilities, programs, or services have met the outcome standards for licensure and are eligible for payment.

Subd. 4. **Appointment of quality assurance manager.** (a) A county or group of counties that chooses to participate in the alternative licensing system shall designate a quality assurance manager and shall establish quality assurance teams in accordance with subdivision 5. The manager shall recruit, train, and assign duties to the quality assurance team members. In assigning team members to conduct the quality assurance process at a facility, program, or service, the manager shall take into account the size of the service provider, the number of services to be reviewed, the skills necessary for team members to complete the process, and other relevant factors. The manager shall ensure that no team member has a financial, personal, or family relationship with the facility, program, or service being reviewed or with any clients of the facility, program, or service.

(b) Quality assurance teams shall report the findings of their quality assurance reviews to the quality assurance manager. The quality assurance manager shall provide the report from the quality assurance team to the county and, upon request, to the commissioners of human services and health, and shall provide a summary of the report to the Quality Assurance Review Council.

Subd. 5. **Quality assurance teams.** Quality assurance teams shall be comprised of county staff; providers; consumers, families, and their legal representatives; members of advocacy organizations; and other involved community members. Team members must satisfactorily complete the training program approved by the commission and must demonstrate performance-based competency. Team members are not considered to be county employees for purposes of workers' compensation, unemployment insurance, or state retirement laws solely on the basis of participation on a quality assurance team. A per diem may be paid to team members for time spent on alternative quality assurance process matters. All team members may be reimbursed for expenses related to their participation in the alternative process.

Subd. 6. **Licensing functions.** Participating counties shall perform licensing functions and activities as delegated by the commissioner of human services in accordance with section 245A.16.

History: *1997 c 203 art 7 s 20; 1Sp2001 c 9 art 3 s 56,57; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 3 s 40; 2004 c 206 s 52; 1Sp2005 c 4 art 7 s 26; 2013 c 108 art 7 s 18,19*

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256B.0953 QUALITY ASSURANCE PROCESS.

Subdivision 1. **Process components.** (a) The quality assurance licensing process consists of an evaluation by a quality assurance team of the facility, program, or service according to outcome-based measurements. The process must include an evaluation of a random sample of program consumers. The sample must be representative of each service provided. The sample size must be at least five percent of consumers but not less than two consumers.

(b) All consumers must be given the opportunity to be included in the quality assurance process in addition to those chosen for the random sample.

Subd. 2. **Licensure periods.** (a) In order to be licensed under the alternative quality assurance licensing system, a facility, program, or service must satisfy the health and safety outcomes approved for the alternative quality assurance licensing system.

(b) Licensure shall be approved for periods of one to three years for a facility, program, or service that satisfies the requirements of paragraph (a) and achieves the outcome measurements in the categories of consumer evaluation, education and training, providers, and systems.

Subd. 3. **Appeals process.** A facility, program, or service may contest a licensing decision of the quality assurance team as permitted under chapter 245A.

History: *1997 c 203 art 7 s 21; 1Sp2003 c 14 art 3 s 41; 1Sp2005 c 4 art 7 s 27*

256B.0954 CERTAIN PERSONS DEFINED AS MANDATED REPORTERS.

Members of the Quality Assurance Commission established under section 256B.0951, members of quality assurance review councils established under section 256B.0952, quality assurance managers appointed under section 256B.0952, and members of quality assurance teams established under section 256B.0952 are mandated reporters as that term is defined in sections 626.556, subdivision 3, and 626.5572, subdivision 16.

History: *1997 c 203 art 7 s 22*

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 quality assurance licensing system. The commissioner shall not license or reimburse a facility, program, or service for persons with disabilities in a county that participates in the alternative quality assurance 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 quality assurance licensing system. The role of such random inspections shall be to verify that the alternative quality assurance licensing system protects the safety and well-being of consumers and maintains the availability of high-quality services for persons with developmental disabilities.

History: *1997 c 203 art 7 s 23; 1999 c 245 art 4 s 65; 1Sp2003 c 14 art 3 s 42; 2013 c 108 art 7 s 20*

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256B.096 Subdivision 1. [Repealed, 2013 c 108 art 7 s 64]

Subd. 2. [Repealed, 2013 c 108 art 7 s 64]

Subd. 3. [Repealed, 2013 c 108 art 7 s 64]

Subd. 4. [Repealed, 2013 c 108 art 7 s 64]

Subd. 5. MS 2012 [Expired, 2012 c 216 art 9 s 25]

256B.097 STATE QUALITY ASSURANCE, QUALITY IMPROVEMENT, AND LICENSING SYSTEM.

Subdivision 1. **Scope.** (a) In order to improve the quality of services provided to Minnesotans with disabilities and to meet the requirements of the federally approved home and community-based waivers under section 1915c of the Social Security Act, a State Quality Assurance, Quality Improvement, and Licensing System for Minnesotans receiving disability services is enacted. This system is a partnership between the Department of Human Services and the State Quality Council established under subdivision 3.

(b) This system is a result of the recommendations from the Department of Human Services' licensing and alternative quality assurance study mandated under Laws 2005, First Special Session chapter 4, article 7, section 57, and presented to the legislature in February 2007.

(c) The disability services eligible under this section include:

(1) the home and community-based services waiver programs for persons with developmental disabilities under section 256B.092, subdivision 4, or section 256B.49, including brain injuries and services for those who qualify for nursing facility level of care or hospital facility level of care and any other services licensed under chapter 245D;

(2) home care services under section 256B.0651;

(3) family support grants under section 252.32;

(4) consumer support grants under section 256.476;

(5) semi-independent living services under section 252.275; and

(6) services provided through an intermediate care facility for the developmentally disabled.

(d) For purposes of this section, the following definitions apply:

(1) "commissioner" means the commissioner of human services;

(2) "council" means the State Quality Council under subdivision 3;

(3) "Quality Assurance Commission" means the commission under section 256B.0951; and

(4) "system" means the State Quality Assurance, Quality Improvement and Licensing System under this section.

Subd. 2. **Duties of commissioner of human services.** (a) The commissioner of human services shall establish the State Quality Council under subdivision 3.

(b) The commissioner shall initially delegate authority to perform licensing functions and activities according to section 245A.16 to a host county in Region 10. The commissioner must not license or reimburse

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a participating facility, program, or service located in Region 10 if the commissioner has received notification from the host county that the facility, program, or service has failed to qualify for licensure.

(c) The commissioner may conduct random licensing inspections based on outcomes adopted under section 256B.0951, subdivision 3, at facilities or programs, and of services eligible under this section. The role of the random inspections is to verify that the system protects the safety and well-being of persons served and maintains the availability of high-quality services for persons with disabilities.

(d) The commissioner shall ensure that the federal home and community-based waiver requirements are met and that incidents that may have jeopardized safety and health or violated services-related assurances, civil and human rights, and other protections designed to prevent abuse, neglect, and exploitation, are reviewed, investigated, and acted upon in a timely manner.

(e) The commissioner shall seek a federal waiver by July 1, 2012, to allow intermediate care facilities for persons with developmental disabilities to participate in this system.

Subd. 3. **State Quality Council.** (a) There is hereby created a State Quality Council which must define regional quality councils, and carry out a community-based, person-directed quality review component, and a comprehensive system for effective incident reporting, investigation, analysis, and follow-up.

(b) By August 1, 2011, the commissioner of human services shall appoint the members of the initial State Quality Council. Members shall include representatives from the following groups:

(1) disability service recipients and their family members;

(2) during the first four years of the State Quality Council, there must be at least three members from the Region 10 stakeholders. As regional quality councils are formed under subdivision 4, each regional quality council shall appoint one member;

(3) disability service providers;

(4) disability advocacy groups; and

(5) county human services agencies and staff from the Department of Human Services and Ombudsman for Mental Health and Developmental Disabilities.

(c) Members of the council who do not receive a salary or wages from an employer for time spent on council duties may receive a per diem payment when performing council duties and functions.

(d) The State Quality Council shall:

(1) assist the Department of Human Services in fulfilling federally mandated obligations by monitoring disability service quality and quality assurance and improvement practices in Minnesota;

(2) establish state quality improvement priorities with methods for achieving results and provide an annual report to the legislative committees with jurisdiction over policy and funding of disability services on the outcomes, improvement priorities, and activities undertaken by the commission during the previous state fiscal year;

(3) identify issues pertaining to financial and personal risk that impede Minnesotans with disabilities from optimizing choice of community-based services; and

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(4) recommend to the chairs and ranking minority members of the legislative committees with jurisdiction over human services and civil law by January 15, 2014, statutory and rule changes related to the findings under clause (3) that promote individualized service and housing choices balanced with appropriate individualized protection.

(e) The State Quality Council, in partnership with the commissioner, shall:

(1) approve and direct implementation of the community-based, person-directed system established in this section;

(2) recommend an appropriate method of funding this system, and determine the feasibility of the use of Medicaid, licensing fees, as well as other possible funding options;

(3) approve measurable outcomes in the areas of health and safety, consumer evaluation, education and training, providers, and systems;

(4) establish variable licensure periods not to exceed three years based on outcomes achieved; and

(5) in cooperation with the Quality Assurance Commission, design a transition plan for licensed providers from Region 10 into the alternative licensing system.

(f) The State Quality Council shall notify the commissioner of human services that a facility, program, or service has been reviewed by quality assurance team members under subdivision 4, paragraph (b), clause (13), and qualifies for a license.

(g) The State Quality Council, in partnership with the commissioner, shall establish an ongoing review process for the system. The review shall take into account the comprehensive nature of the system which is designed to evaluate the broad spectrum of licensed and unlicensed entities that provide services to persons with disabilities. The review shall address efficiencies and effectiveness of the system.

(h) The State Quality Council may recommend to the commissioner certain variances from the standards governing licensure of programs for persons with disabilities in order to improve the quality of services so long as the recommended variances do not adversely affect the health or safety of persons being served or compromise the qualifications of staff to provide services.

(i) The safety standards, rights, or procedural protections referenced under subdivision 2, paragraph (c), shall not be varied. The State Quality Council may make recommendations to the commissioner or to the legislature in the report required under paragraph (c) regarding alternatives or modifications to the safety standards, rights, or procedural protections referenced under subdivision 2, paragraph (c).

(j) The State Quality Council may hire staff to perform the duties assigned in this subdivision.

Subd. 4. **Regional quality councils.** (a) The commissioner shall establish, as selected by the State Quality Council, regional quality councils of key stakeholders, including regional representatives of:

(1) disability service recipients and their family members;

(2) disability service providers;

(3) disability advocacy groups; and

(4) county human services agencies and staff from the Department of Human Services and Ombudsman for Mental Health and Developmental Disabilities.

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(b) Each regional quality council shall:

(1) direct and monitor the community-based, person-directed quality assurance system in this section;

(2) approve a training program for quality assurance team members under clause (13);

(3) review summary reports from quality assurance team reviews and make recommendations to the State Quality Council regarding program licensure;

(4) make recommendations to the State Quality Council regarding the system;

(5) resolve complaints between the quality assurance teams, counties, providers, persons receiving services, their families, and legal representatives;

(6) analyze and review quality outcomes and critical incident data reporting incidents of life safety concerns immediately to the Department of Human Services licensing division;

(7) provide information and training programs for persons with disabilities and their families and legal representatives on service options and quality expectations;

(8) disseminate information and resources developed to other regional quality councils;

(9) respond to state-level priorities;

(10) establish regional priorities for quality improvement;

(11) submit an annual report to the State Quality Council on the status, outcomes, improvement priorities, and activities in the region;

(12) choose a representative to participate on the State Quality Council and assume other responsibilities consistent with the priorities of the State Quality Council; and

(13) recruit, train, and assign duties to members of quality assurance teams, taking into account the size of the service provider, the number of services to be reviewed, the skills necessary for the team members to complete the process, and ensure that no team member has a financial, personal, or family relationship with the facility, program, or service being reviewed or with anyone served at the facility, program, or service. Quality assurance teams must be comprised of county staff, persons receiving services or the person's families, legal representatives, members of advocacy organizations, providers, and other involved community members. Team members must complete the training program approved by the regional quality council and must demonstrate performance-based competency. Team members may be paid a per diem and reimbursed for expenses related to their participation in the quality assurance process.

(c) The commissioner shall monitor the safety standards, rights, and procedural protections for the monitoring of psychotropic medications and those identified under sections 245.825; 245.91 to 245.97; 245A.09, subdivision 2, paragraph (c), clauses (2) and (5); 245A.12; 245A.13; 252.41, subdivision 9; 256B.092, subdivision 1b, clause (7); 626.556; and 626.557.

(d) The regional quality councils may hire staff to perform the duties assigned in this subdivision.

(e) The regional quality councils may charge fees for their services.

(f) The quality assurance process undertaken by a regional quality council consists of an evaluation by a quality assurance team of the facility, program, or service. The process must include an evaluation

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of a random sample of persons served. The sample must be representative of each service provided. The sample size must be at least five percent but not less than two persons served. All persons must be given the opportunity to be included in the quality assurance process in addition to those chosen for the random sample.

(g) A facility, program, or service may contest a licensing decision of the regional quality council as permitted under chapter 245A.

Subd. 5. **Annual survey of service recipients.** The commissioner, in consultation with the State Quality Council, shall conduct an annual independent statewide survey of service recipients, randomly selected, to determine the effectiveness and quality of disability services. The survey must be consistent with the system performance expectations of the Centers for Medicare and Medicaid Services (CMS) Quality Framework. The survey must analyze whether desired outcomes for persons with different demographic, diagnostic, health, and functional needs, who are receiving different types of services in different settings and with different costs, have been achieved. Annual statewide and regional reports of the results must be published and used to assist regions, counties, and providers to plan and measure the impact of quality improvement activities.

Subd. 6. **Mandated reporters.** Members of the State Quality Council under subdivision 3, the regional quality councils under subdivision 4, and quality assurance team members under subdivision 4, paragraph (b), clause (13), are mandated reporters as defined in sections 626.556, subdivision 3, and 626.5572, subdivision 16.

History: *1Sp2011 c 9 art 7 s 23; 2012 c 216 art 14 s 2; 2012 c 247 art 4 s 28; 2013 c 108 art 7 s 21,22*

256B.10 [Repealed, 1976 c 131 s 2]

256B.11 [Repealed, 1976 c 131 s 2]

256B.12 LEGAL REPRESENTATION.

The attorney general or the appropriate county attorney appearing at the direction of the attorney general shall be the attorney for the state agency, and the county attorney of the appropriate county shall be the attorney for the local agency in all matters pertaining hereto. To prosecute under this chapter or sections 609.466 and 609.52, subdivision 2, or to recover payments wrongfully made under this chapter, the attorney general or the appropriate county attorney, acting independently or at the direction of the attorney general may institute a criminal or civil action.

History: *Ex1967 c 16 s 12; 1975 c 437 art 2 s 6; 1976 c 188 s 2*

256B.121 TREBLE DAMAGES.

Any vendor of medical care who willfully submits a cost report, rate application or claim for reimbursement for medical care which the vendor knows is a false representation and which results in the payment of public funds for which the vendor is ineligible shall, in addition to other provisions of Minnesota law, be subject to an action by the state of Minnesota or any of its subdivisions or agencies for civil damages. The damages awarded shall include three times the payments which result from the false representation, together with costs and disbursements, including reasonable attorney fees or their equivalent.

History: *1976 c 188 s 4*

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256B.13 SUBPOENAS.

Each county agency and the state agency shall have the power to issue subpoenas for witnesses and compel their attendance and the production of papers and writing; and officers and employees designated by any county agency or the state agency may administer oaths and examine witnesses under oath in connection with any application or proceedings hereunder.

History: *Ex1967 c 16 s 13*

256B.14 RELATIVE'S RESPONSIBILITY.

Subdivision 1. **In general.** Subject to the provisions of sections 256B.055, 256B.056, and 256B.06, responsible relative means the parent of a minor recipient of medical assistance or the spouse of a medical assistance recipient.

Subd. 2. **Actions to obtain payment.** The state agency shall promulgate rules to determine the ability of responsible relatives to contribute partial or complete payment or repayment of medical assistance furnished to recipients for whom they are responsible. All medical assistance exclusions shall be allowed, and a resource limit of $10,000 for nonexcluded resources shall be implemented. Above these limits, a contribution of one-third of the excess resources shall be required. These rules shall not require payment or repayment when payment would cause undue hardship to the responsible relative or that relative's immediate family. These rules shall be consistent with the requirements of section 252.27 for parents of children whose eligibility for medical assistance was determined without deeming of the parents' resources and income. The county agency shall give the responsible relative notice of the amount of the payment or repayment. If the state agency or county agency finds that notice of the payment obligation was given to the responsible relative, but that the relative failed or refused to pay, a cause of action exists against the responsible relative for that portion of medical assistance granted after notice was given to the responsible relative, which the relative was determined to be able to pay.

The action may be brought by the state agency or the county agency in the county where assistance was granted, for the assistance, together with the costs of disbursements incurred due to the action.

In addition to granting the county or state agency a money judgment, the court may, upon a motion or order to show cause, order continuing contributions by a responsible relative found able to repay the county or state agency. The order shall be effective only for the period of time during which the recipient receives medical assistance from the county or state agency.

Subd. 3. **Community spouse contribution.** The community spouse of an institutionalized person who receives medical assistance under section 256B.059, subdivision 5, paragraph (b), has an obligation to pay for the cost of care equal to the dollar value of assets considered available under section 256B.059, subdivision 5.

Subd. 3a. [Repealed, 2013 c 108 art 7 s 64]

Subd. 4. **Appeals.** A responsible relative may appeal the determination of an obligation to make a contribution under this section according to section 256.045.

History: *Ex1967 c 16 s 14; 1973 c 725 s 46; 1977 c 448 s 7; 1982 c 640 s 6; 1983 c 312 art 5 s 19; 1984 c 530 s 4; 1986 c 444; 1988 c 689 art 2 s 150,268,270; 1989 c 282 art 3 s 63; 1990 c 568 art 3 s 62; 1992 c 513 art 7 s 79; 1Sp2011 c 9 art 3 s 5*

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256B.15 CLAIMS AGAINST ESTATES.

Subdivision 1. **Policy and applicability.** (a) It is the policy of this state that individuals or couples, either or both of whom participate in the medical assistance program, use their own assets to pay their share of the total cost of their care during or after their enrollment in the program according to applicable federal law and the laws of this state. The following provisions apply:

(1) subdivisions 1c to 1k shall not apply to claims arising under this section which are presented under section 525.313;

(2) the provisions of subdivisions 1c to 1k expanding the interests included in an estate for purposes of recovery under this section give effect to the provisions of United States Code, title 42, section 1396p, governing recoveries, but do not give rise to any express or implied liens in favor of any other parties not named in these provisions;

(3) the continuation of a recipient's life estate or joint tenancy interest in real property after the recipient's death for the purpose of recovering medical assistance under this section modifies common law principles holding that these interests terminate on the death of the holder;

(4) all laws, rules, and regulations governing or involved with a recovery of medical assistance shall be liberally construed to accomplish their intended purposes;

(5) a deceased recipient's life estate and joint tenancy interests continued under this section shall be owned by the remainderpersons or surviving joint tenants as their interests may appear on the date of the recipient's death. They shall not be merged into the remainder interest or the interests of the surviving joint tenants by reason of ownership. They shall be subject to the provisions of this section. Any conveyance, transfer, sale, assignment, or encumbrance by a remainderperson, a surviving joint tenant, or their heirs, successors, and assigns shall be deemed to include all of their interest in the deceased recipient's life estate or joint tenancy interest continued under this section; and

(6) the provisions of subdivisions 1c to 1k continuing a recipient's joint tenancy interests in real property after the recipient's death do not apply to a homestead owned of record, on the date the recipient dies, by the recipient and the recipient's spouse as joint tenants with a right of survivorship. Homestead means the real property occupied by the surviving joint tenant spouse as their sole residence on the date the recipient dies and classified and taxed to the recipient and surviving joint tenant spouse as homestead property for property tax purposes in the calendar year in which the recipient dies. For purposes of this exemption, real property the recipient and their surviving joint tenant spouse purchase solely with the proceeds from the sale of their prior homestead, own of record as joint tenants, and qualify as homestead property under section 273.124 in the calendar year in which the recipient dies and prior to the recipient's death shall be deemed to be real property classified and taxed to the recipient and their surviving joint tenant spouse as homestead property in the calendar year in which the recipient dies. The surviving spouse, or any person with personal knowledge of the facts, may provide an affidavit describing the homestead property affected by this clause and stating facts showing compliance with this clause. The affidavit shall be prima facie evidence of the facts it states.

(b) For purposes of this section, "medical assistance" includes the medical assistance program under this chapter and the general assistance medical care program under chapter 256D and alternative care for nonmedical assistance recipients under section 256B.0913.

(c) For purposes of this section, beginning January 1, 2010, "medical assistance" does not include Medicare cost-sharing benefits in accordance with United States Code, title 42, section 1396p.

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(d) All provisions in this subdivision, and subdivisions 1d, 1f, 1g, 1h, 1i, and 1j, related to the continuation of a recipient's life estate or joint tenancy interests in real property after the recipient's death for the purpose of recovering medical assistance, are effective only for life estates and joint tenancy interests established on or after August 1, 2003. For purposes of this paragraph, medical assistance does not include alternative care.

Subd. 1a. **Estates subject to claims.** (a) If a person receives any medical assistance hereunder, on the person's death, if single, or on the death of the survivor of a married couple, either or both of whom received medical assistance, or as otherwise provided for in this section, the total amount paid for medical assistance rendered for the person and spouse shall be filed as a claim against the estate of the person or the estate of the surviving spouse in the court having jurisdiction to probate the estate or to issue a decree of descent according to sections 525.31 to 525.313.

(b) For the purposes of this section, the person's estate must consist of:

(1) the person's probate estate;

(2) all of the person's interests or proceeds of those interests in real property the person owned as a life tenant or as a joint tenant with a right of survivorship at the time of the person's death;

(3) all of the person's interests or proceeds of those interests in securities the person owned in beneficiary form as provided under sections 524.6-301 to 524.6-311 at the time of the person's death, to the extent the interests or proceeds of those interests become part of the probate estate under section 524.6-307;

(4) all of the person's interests in joint accounts, multiple-party accounts, and pay-on-death accounts, brokerage accounts, investment accounts, or the proceeds of those accounts, as provided under sections 524.6-201 to 524.6-214 at the time of the person's death to the extent the interests become part of the probate estate under section 524.6-207; and

(5) assets conveyed to a survivor, heir, or assign of the person through survivorship, living trust, or other arrangements.

(c) For the purpose of this section and recovery in a surviving spouse's estate for medical assistance paid for a predeceased spouse, the estate must consist of all of the legal title and interests the deceased individual's predeceased spouse had in jointly owned or marital property at the time of the spouse's death, as defined in subdivision 2b, and the proceeds of those interests, that passed to the deceased individual or another individual, a survivor, an heir, or an assign of the predeceased spouse through a joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement. A deceased recipient who, at death, owned the property jointly with the surviving spouse shall have an interest in the entire property.

(d) For the purpose of recovery in a single person's estate or the estate of a survivor of a married couple, "other arrangement" includes any other means by which title to all or any part of the jointly owned or marital property or interest passed from the predeceased spouse to another including, but not limited to, transfers between spouses which are permitted, prohibited, or penalized for purposes of medical assistance.

(e) A claim shall be filed if medical assistance was rendered for either or both persons under one of the following circumstances:

(1) the person was over 55 years of age, and received services under this chapter;

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(2) the person resided in a medical institution for six months or longer, received services under this chapter, and, at the time of institutionalization or application for medical assistance, whichever is later, the person could not have reasonably been expected to be discharged and returned home, as certified in writing by the person's treating physician. For purposes of this section only, a "medical institution" means a skilled nursing facility, intermediate care facility, intermediate care facility for persons with developmental disabilities, nursing facility, or inpatient hospital; or

(3) the person received general assistance medical care services under chapter 256D.

(f) The claim shall be considered an expense of the last illness of the decedent for the purpose of section 524.3-805. Notwithstanding any law or rule to the contrary, a state or county agency with a claim under this section must be a creditor under section 524.6-307. Any statute of limitations that purports to limit any county agency or the state agency, or both, to recover for medical assistance granted hereunder shall not apply to any claim made hereunder for reimbursement for any medical assistance granted hereunder. Notice of the claim shall be given to all heirs and devisees of the decedent, and to other persons with an ownership interest in the real property owned by the decedent at the time of the decedent's death, whose identity can be ascertained with reasonable diligence. The notice must include procedures and instructions for making an application for a hardship waiver under subdivision 5; time frames for submitting an application and determination; and information regarding appeal rights and procedures. Counties are entitled to one-half of the nonfederal share of medical assistance collections from estates that are directly attributable to county effort. Counties are entitled to ten percent of the collections for alternative care directly attributable to county effort.

[See Note.]

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

Subd. 1c. **Notice of potential claim.** (a) A state agency with a claim or potential claim under this section may file a notice of potential claim under this subdivision anytime before or within one year after a medical assistance recipient dies. The claimant shall be the state agency. A notice filed prior to the recipient's death shall not take effect and shall not be effective as notice until the recipient dies. A notice filed after a recipient dies shall be effective from the time of filing.

(b) The notice of claim shall be filed or recorded in the real estate records in the office of the county recorder or registrar of titles for each county in which any part of the property is located. The recorder shall accept the notice for recording or filing. The registrar of titles shall accept the notice for filing if the recipient has a recorded interest in the property. The registrar of titles shall not carry forward to a new certificate of title any notice filed more than one year from the date of the recipient's death.

(c) The notice must be dated, state the name of the claimant, the medical assistance recipient's name and last four digits of the Social Security number if filed before their death and their date of death if filed after they die, the name and date of death of any predeceased spouse of the medical assistance recipient for whom a claim may exist, a statement that the claimant may have a claim arising under this section, generally identify the recipient's interest in the property, contain a legal description for the property and whether it is abstract or registered property, a statement of when the notice becomes effective and the effect of the notice, be signed by an authorized representative of the state agency, and may include such other contents as the state agency may deem appropriate.

Subd. 1d. **Effect of notice.** From the time it takes effect, the notice shall be notice to remainderpersons, joint tenants, or to anyone else owning or acquiring an interest in or encumbrance against the property

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described in the notice that the medical assistance recipient's life estate, joint tenancy, or other interests in the real estate described in the notice:

(1) shall, in the case of life estate and joint tenancy interests, continue to exist for purposes of this section, and be subject to liens and claims as provided in this section;

(2) shall be subject to a lien in favor of the claimant effective upon the death of the recipient and dealt with as provided in this section;

(3) may be included in the recipient's estate, as defined in this section; and

(4) may be subject to administration and all other provisions of chapter 524 and may be sold, assigned, transferred, or encumbered free and clear of their interest or encumbrance to satisfy claims under this section.

Subd. 1e. **Full or partial release of notice.** (a) The claimant may fully or partially release the notice and the lien arising out of the notice of record in the real estate records where the notice is filed or recorded at any time. The claimant may give a full or partial release to extinguish any life estates or joint tenancy interests which are or may be continued under this section or whose existence or nonexistence may create a cloud on the title to real property at any time whether or not a notice has been filed. The recorder or registrar of titles shall accept the release for recording or filing. If the release is a partial release, it must include a legal description of the property being released.

(b) At any time, the claimant may, at the claimant's discretion, wholly or partially release, subordinate, modify, or amend the recorded notice and the lien arising out of the notice.

Subd. 1f. **Agency lien.** (a) The notice shall constitute a lien in favor of the Department of Human Services against the recipient's interests in the real estate it describes for a period of 20 years from the date of filing or the date of the recipient's death, whichever is later. Notwithstanding any law or rule to the contrary, a recipient's life estate and joint tenancy interests shall not end upon the recipient's death but shall continue according to subdivisions 1h, 1i, and 1j. The amount of the lien shall be equal to the total amount of the claims that could be presented in the recipient's estate under this section.

(b) If no estate has been opened for the deceased recipient, any holder of an interest in the property may apply to the lienholder for a statement of the amount of the lien or for a full or partial release of the lien. The application shall include the applicant's name, current mailing address, current home and work telephone numbers, and a description of their interest in the property, a legal description of the recipient's interest in the property, and the deceased recipient's name, date of birth, and last four digits of the Social Security number. The lienholder shall send the applicant by certified mail, return receipt requested, a written statement showing the amount of the lien, whether the lienholder is willing to release the lien and under what conditions, and inform them of the right to a hearing under section 256.045. The lienholder shall have the discretion to compromise and settle the lien upon any terms and conditions the lienholder deems appropriate.

(c) Any holder of an interest in property subject to the lien has a right to request a hearing under section 256.045 to determine the validity, extent, or amount of the lien. The request must be in writing, and must include the names, current addresses, and home and business telephone numbers for all other parties holding an interest in the property. A request for a hearing by any holder of an interest in the property shall be deemed to be a request for a hearing by all parties owning interests in the property. Notice of the hearing shall be given to the lienholder, the party filing the appeal, and all of the other holders of interests in the property at the addresses listed in the appeal by certified mail, return receipt requested, or by ordinary mail. Any owner of an interest in the property to whom notice of the hearing is mailed shall be deemed to have

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waived any and all claims or defenses in respect to the lien unless they appear and assert any claims or defenses at the hearing.

(d) If the claim the lien secures could be filed under subdivision 1h, the lienholder may collect, compromise, settle, or release the lien upon any terms and conditions it deems appropriate. If the claim the lien secures could be filed under subdivision 1i or 1j, the lien may be adjusted or enforced to the same extent had it been filed under subdivisions 1i and 1j, and the provisions of subdivisions 1i, clause (f), and 1j, clause (d), shall apply to voluntary payment, settlement, or satisfaction of the lien.

(e) If no probate proceedings have been commenced for the recipient as of the date the lien holder executes a release of the lien on a recipient's life estate or joint tenancy interest, created for purposes of this section, the release shall terminate the life estate or joint tenancy interest created under this section as of the date it is recorded or filed to the extent of the release. If the claimant executes a release for purposes of extinguishing a life estate or a joint tenancy interest created under this section to remove a cloud on title to real property, the release shall have the effect of extinguishing any life estate or joint tenancy interests in the property it describes which may have been continued by reason of this section retroactive to the date of death of the deceased life tenant or joint tenant except as provided for in section 514.981, subdivision 6.

(f) If the deceased recipient's estate is probated, a claim shall be filed under this section. The amount of the lien shall be limited to the amount of the claim as finally allowed. If the claim the lien secures is filed under subdivision 1h, the lien may be released in full after any allowance of the claim becomes final or according to any agreement to settle and satisfy the claim. The release shall release the lien but shall not extinguish or terminate the interest being released. If the claim the lien secures is filed under subdivision 1i or 1j, the lien shall be released after the lien under subdivision 1i or 1j is filed or recorded, or settled according to any agreement to settle and satisfy the claim. The release shall not extinguish or terminate the interest being released. If the claim is finally disallowed in full, the claimant shall release the claimant's lien at the claimant's expense.

Subd. 1g. **Estate property.** Notwithstanding any law or rule to the contrary, if a claim is presented under this section, interests or the proceeds of interests in real property a decedent owned as a life tenant or a joint tenant with a right of survivorship shall be part of the decedent's estate, subject to administration, and shall be dealt with as provided in this section.

Subd. 1h. **Estates of specific persons receiving medical assistance.** (a) For purposes of this section, paragraphs (b) to (j) apply if a person received medical assistance for which a claim may be filed under this section and died single, or the surviving spouse of the couple and was not survived by any of the persons described in subdivisions 3 and 4.

(b) Notwithstanding any law or rule to the contrary, the person's life estate or joint tenancy interest in real property not subject to a medical assistance lien under sections 514.980 to 514.985 on the date of the person's death shall not end upon the person's death and shall continue as provided in this subdivision. The life estate in the person's estate shall be that portion of the interest in the real property subject to the life estate that is equal to the life estate percentage factor for the life estate as listed in the Life Estate Mortality Table of the health care program's manual for a person who was the age of the medical assistance recipient on the date of the person's death. The joint tenancy interest in real property in the estate shall be equal to the fractional interest the person would have owned in the jointly held interest in the property had they and the other owners held title to the property as tenants in common on the date the person died.

(c) The court upon its own motion, or upon motion by the personal representative or any interested party, may enter an order directing the remainderpersons or surviving joint tenants and their spouses, if

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any, to sign all documents, take all actions, and otherwise fully cooperate with the personal representative and the court to liquidate the decedent's life estate or joint tenancy interests in the estate and deliver the cash or the proceeds of those interests to the personal representative and provide for any legal and equitable sanctions as the court deems appropriate to enforce and carry out the order, including an award of reasonable attorney fees.

(d) The personal representative may make, execute, and deliver any conveyances or other documents necessary to convey the decedent's life estate or joint tenancy interest in the estate that are necessary to liquidate and reduce to cash the decedent's interest or for any other purposes.

(e) Subject to administration, all costs, including reasonable attorney fees, directly and immediately related to liquidating the decedent's life estate or joint tenancy interest in the decedent's estate, shall be paid from the gross proceeds of the liquidation allocable to the decedent's interest and the net proceeds shall be turned over to the personal representative and applied to payment of the claim presented under this section.

(f) The personal representative shall bring a motion in the district court in which the estate is being probated to compel the remainderpersons or surviving joint tenants to account for and deliver to the personal representative all or any part of the proceeds of any sale, mortgage, transfer, conveyance, or any disposition of real property allocable to the decedent's life estate or joint tenancy interest in the decedent's estate, and do everything necessary to liquidate and reduce to cash the decedent's interest and turn the proceeds of the sale or other disposition over to the personal representative. The court may grant any legal or equitable relief including, but not limited to, ordering a partition of real estate under chapter 558 necessary to make the value of the decedent's life estate or joint tenancy interest available to the estate for payment of a claim under this section.

(g) Subject to administration, the personal representative shall use all of the cash or proceeds of interests to pay an allowable claim under this section. The remainderpersons or surviving joint tenants and their spouses, if any, may enter into a written agreement with the personal representative or the claimant to settle and satisfy obligations imposed at any time before or after a claim is filed.

(h) The personal representative may, at their discretion, provide any or all of the other owners, remainderpersons, or surviving joint tenants with an affidavit terminating the decedent's estate's interest in real property the decedent owned as a life tenant or as a joint tenant with others, if the personal representative determines in good faith that neither the decedent nor any of the decedent's predeceased spouses received any medical assistance for which a claim could be filed under this section, or if the personal representative has filed an affidavit with the court that the estate has other assets sufficient to pay a claim, as presented, or if there is a written agreement under paragraph (g), or if the claim, as allowed, has been paid in full or to the full extent of the assets the estate has available to pay it. The affidavit may be recorded in the office of the county recorder or filed in the Office of the Registrar of Titles for the county in which the real property is located. Except as provided in section 514.981, subdivision 6, when recorded or filed, the affidavit shall terminate the decedent's interest in real estate the decedent owned as a life tenant or a joint tenant with others. The affidavit shall:

(1) be signed by the personal representative;

(2) identify the decedent and the interest being terminated;

(3) give recording information sufficient to identify the instrument that created the interest in real property being terminated;

(4) legally describe the affected real property;

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(5) state that the personal representative has determined that neither the decedent nor any of the decedent's predeceased spouses received any medical assistance for which a claim could be filed under this section;

(6) state that the decedent's estate has other assets sufficient to pay the claim, as presented, or that there is a written agreement between the personal representative and the claimant and the other owners or remainderpersons or other joint tenants to satisfy the obligations imposed under this subdivision; and

(7) state that the affidavit is being given to terminate the estate's interest under this subdivision, and any other contents as may be appropriate.

The recorder or registrar of titles shall accept the affidavit for recording or filing. The affidavit shall be effective as provided in this section and shall constitute notice even if it does not include recording information sufficient to identify the instrument creating the interest it terminates. The affidavit shall be conclusive evidence of the stated facts.

(i) The holder of a lien arising under subdivision 1c shall release the lien at the holder's expense against an interest terminated under paragraph (g) to the extent of the termination.

(j) If a lien arising under subdivision 1c is not released under paragraph (i), prior to closing the estate, the personal representative shall deed the interest subject to the lien to the remainderpersons or surviving joint tenants as their interests may appear. Upon recording or filing, the deed shall work a merger of the recipient's life estate or joint tenancy interest, subject to the lien, into the remainder interest or interest the decedent and others owned jointly. The lien shall attach to and run with the property to the extent of the decedent's interest at the time of the decedent's death.

Subd. 1i. **Estates of persons receiving medical assistance and survived by others.** (a) For purposes of this subdivision, the person's estate consists of the person's probate estate and all of the person's interests in real property the person owned as a life tenant or a joint tenant at the time of the person's death and the person's legal title or interest at the time of the person's death in real property transferred to a beneficiary under a transfer on death deed under section 507.071, or in the proceeds from the subsequent sale of the person's interest in the transferred real property.

(b) Notwithstanding any law or rule to the contrary, this subdivision applies if a person received medical assistance for which a claim could be filed under this section but for the fact the person was survived by a spouse or by a person listed in subdivision 3, or if subdivision 4 applies to a claim arising under this section.

(c) The person's life estate or joint tenancy interests in real property not subject to a medical assistance lien under sections 514.980 to 514.985 on the date of the person's death shall not end upon death and shall continue as provided in this subdivision. The life estate in the estate shall be the portion of the interest in the property subject to the life estate that is equal to the life estate percentage factor for the life estate as listed in the Life Estate Mortality Table of the health care program's manual for a person who was the age of the medical assistance recipient on the date of the person's death. The joint tenancy interest in the estate shall be equal to the fractional interest the medical assistance recipient would have owned in the jointly held interest in the property had they and the other owners held title to the property as tenants in common on the date the medical assistance recipient died.

(d) The county agency shall file a claim in the estate under this section on behalf of the claimant who shall be the commissioner of human services, notwithstanding that the decedent is survived by a spouse or a person listed in subdivision 3. The claim, as allowed, shall not be paid by the estate and shall be disposed

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of as provided in this paragraph. The personal representative or the court shall make, execute, and deliver a lien in favor of the claimant on the decedent's interest in real property in the estate in the amount of the allowed claim on forms provided by the commissioner to the county agency filing the lien. The lien shall bear interest as provided under section 524.3-806, shall attach to the property it describes upon filing or recording, and shall remain a lien on the real property it describes for a period of 20 years from the date it is filed or recorded. The lien shall be a disposition of the claim sufficient to permit the estate to close.

(e) The state or county agency shall file or record the lien in the office of the county recorder or registrar of titles for each county in which any of the real property is located. The recorder or registrar of titles shall accept the lien for filing or recording. All recording or filing fees shall be paid by the Department of Human Services. The recorder or registrar of titles shall mail the recorded lien to the Department of Human Services. The lien need not be attested, certified, or acknowledged as a condition of recording or filing. Upon recording or filing of a lien against a life estate or a joint tenancy interest, the interest subject to the lien shall merge into the remainder interest or the interest the recipient and others owned jointly. The lien shall attach to and run with the property to the extent of the decedent's interest in the property at the time of the decedent's death as determined under this section.

(f) The department shall make no adjustment or recovery under the lien until after the decedent's spouse, if any, has died, and only at a time when the decedent has no surviving child described in subdivision 3. The estate, any owner of an interest in the property which is or may be subject to the lien, or any other interested party, may voluntarily pay off, settle, or otherwise satisfy the claim secured or to be secured by the lien at any time before or after the lien is filed or recorded. Such payoffs, settlements, and satisfactions shall be deemed to be voluntary repayments of past medical assistance payments for the benefit of the deceased recipient, and neither the process of settling the claim, the payment of the claim, or the acceptance of a payment shall constitute an adjustment or recovery that is prohibited under this subdivision.

(g) The lien under this subdivision may be enforced or foreclosed in the manner provided by law for the enforcement of judgment liens against real estate or by a foreclosure by action under chapter 581. When the lien is paid, satisfied, or otherwise discharged, the state or county agency shall prepare and file a release of lien at its own expense. No action to foreclose the lien shall be commenced unless the lienholder has first given 30 days' prior written notice to pay the lien to the owners and parties in possession of the property subject to the lien. The notice shall:

(1) include the name, address, and telephone number of the lienholder;

(2) describe the lien;

(3) give the amount of the lien;

(4) inform the owner or party in possession that payment of the lien in full must be made to the lienholder within 30 days after service of the notice or the lienholder may begin proceedings to foreclose the lien; and

(5) be served by personal service, certified mail, return receipt requested, ordinary first class mail, or by publishing it once in a newspaper of general circulation in the county in which any part of the property is located. Service of the notice shall be complete upon mailing or publication.

Subd. 1j. **Claims in estates of decedents survived by other survivors.** For purposes of this subdivision, the provisions in subdivision 1i, paragraphs (a) to (c) apply.

(a) If payment of a claim filed under this section is limited as provided in subdivision 4, and if the estate does not have other assets sufficient to pay the claim in full, as allowed, the personal representative or the

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court shall make, execute, and deliver a lien on the property in the estate that is exempt from the claim under subdivision 4 in favor of the commissioner of human services on forms provided by the commissioner to the county agency filing the claim. If the estate pays a claim filed under this section in full from other assets of the estate, no lien shall be filed against the property described in subdivision 4.

(b) The lien shall be in an amount equal to the unpaid balance of the allowed claim under this section remaining after the estate has applied all other available assets of the estate to pay the claim. The property exempt under subdivision 4 shall not be sold, assigned, transferred, conveyed, encumbered, or distributed until after the personal representative has determined the estate has other assets sufficient to pay the allowed claim in full, or until after the lien has been filed or recorded. The lien shall bear interest as provided under section 524.3-806, shall attach to the property it describes upon filing or recording, and shall remain a lien on the real property it describes for a period of 20 years from the date it is filed or recorded. The lien shall be a disposition of the claim sufficient to permit the estate to close.

(c) The state or county agency shall file or record the lien in the office of the county recorder or registrar of titles in each county in which any of the real property is located. The department shall pay the filing fees. The lien need not be attested, certified, or acknowledged as a condition of recording or filing. The recorder or registrar of titles shall accept the lien for filing or recording.

(d) The commissioner shall make no adjustment or recovery under the lien until none of the persons listed in subdivision 4 are residing on the property or until the property is sold or transferred. The estate or any owner of an interest in the property that is or may be subject to the lien, or any other interested party, may voluntarily pay off, settle, or otherwise satisfy the claim secured or to be secured by the lien at any time before or after the lien is filed or recorded. The payoffs, settlements, and satisfactions shall be deemed to be voluntary repayments of past medical assistance payments for the benefit of the deceased recipient and neither the process of settling the claim, the payment of the claim, or acceptance of a payment shall constitute an adjustment or recovery that is prohibited under this subdivision.

(e) A lien under this subdivision may be enforced or foreclosed in the manner provided for by law for the enforcement of judgment liens against real estate or by a foreclosure by action under chapter 581. When the lien has been paid, satisfied, or otherwise discharged, the claimant shall prepare and file a release of lien at the claimant's expense. No action to foreclose the lien shall be commenced unless the lienholder has first given 30 days prior written notice to pay the lien to the record owners of the property and the parties in possession of the property subject to the lien. The notice shall:

(1) include the name, address, and telephone number of the lienholder;

(2) describe the lien;

(3) give the amount of the lien;

(4) inform the owner or party in possession that payment of the lien in full must be made to the lienholder within 30 days after service of the notice or the lienholder may begin proceedings to foreclose the lien; and

(5) be served by personal service, certified mail, return receipt requested, ordinary first class mail, or by publishing it once in a newspaper of general circulation in the county in which any part of the property is located. Service shall be complete upon mailing or publication.

(f) Upon filing or recording of a lien against a life estate or joint tenancy interest under this subdivision, the interest subject to the lien shall merge into the remainder interest or the interest the decedent and others

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owned jointly, effective on the date of recording and filing. The lien shall attach to and run with the property to the extent of the decedent's interest in the property at the time of the decedent's death as determined under this section.

(g)(1) An affidavit may be provided by a personal representative, at their discretion, stating the personal representative has determined in good faith that a decedent survived by a spouse or a person listed in subdivision 3, or by a person listed in subdivision 4, or the decedent's predeceased spouse did not receive any medical assistance giving rise to a claim under this section, or that the real property described in subdivision 4 is not needed to pay in full a claim arising under this section.

(2) The affidavit shall:

(i) describe the property and the interest being extinguished;

(ii) name the decedent and give the date of death;

(iii) state the facts listed in clause (1);

(iv) state that the affidavit is being filed to terminate the life estate or joint tenancy interest created under this subdivision;

(v) be signed by the personal representative; and

(vi) contain any other information that the affiant deems appropriate.

(3) Except as provided in section 514.981, subdivision 6, when the affidavit is filed or recorded, the life estate or joint tenancy interest in real property that the affidavit describes shall be terminated effective as of the date of filing or recording. The termination shall be final and may not be set aside for any reason.

Subd. 1k. **Filing.** Any notice, lien, release, or other document filed under subdivisions 1c to 1l, and any lien, release of lien, or other documents relating to a lien filed under subdivisions 1h, 1i, and 1j must be filed or recorded in the office of the county recorder or registrar of titles, as appropriate, in the county where the affected real property is located. Notwithstanding section 386.77, the state or county agency shall pay any applicable filing fee. An attestation, certification, or acknowledgment is not required as a condition of filing. If the property described in the filing is registered property, the registrar of titles shall record the filing on the certificate of title for each parcel of property described in the filing. If the property described in the filing is abstract property, the recorder shall file and index the property in the county's grantor-grantee indexes and any tract indexes the county maintains for each parcel of property described in the filing. The recorder or registrar of titles shall return the filed document to the party filing it at no cost. If the party making the filing provides a duplicate copy of the filing, the recorder or registrar of titles shall show the recording or filing data on the copy and return it to the party at no extra cost.

Subd. 2. **Limitations on claims.** The claim shall include only the total amount of medical assistance rendered after age 55 or during a period of institutionalization described in subdivision 1a, paragraph (e), and the total amount of general assistance medical care rendered, and shall not include interest. Claims that have been allowed but not paid shall bear interest according to section 524.3-806, paragraph (d). A claim against the estate of a surviving spouse who did not receive medical assistance, for medical assistance rendered for the predeceased spouse, shall be payable from the full value of all of the predeceased spouse's assets and interests which are part of the surviving spouse's estate under subdivisions 1a and 2b. Recovery of medical assistance expenses in the nonrecipient surviving spouse's estate is limited to the value of the assets of the

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estate that were marital property or jointly owned property at any time during the marriage. The claim is not payable from the value of assets or proceeds of assets in the estate attributable to a predeceased spouse whom the individual married after the death of the predeceased recipient spouse for whom the claim is filed or from assets and the proceeds of assets in the estate which the nonrecipient decedent spouse acquired with assets which were not marital property or jointly owned property after the death of the predeceased recipient spouse. Claims for alternative care shall be net of all premiums paid under section 256B.0913, subdivision 12, on or after July 1, 2003, and shall be limited to services provided on or after July 1, 2003. Claims against marital property shall be limited to claims against recipients who died on or after July 1, 2009.

[See Note.]

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

Subd. 2b. **Controlling provisions.** (a) For purposes of this subdivision and subdivisions 1a and 2, paragraphs (b) to (d) apply.

(b) At the time of death of a recipient spouse and solely for purpose of recovery of medical assistance benefits received, a predeceased recipient spouse shall have a legal title or interest in the undivided whole of all of the property which the recipient and the recipient's surviving spouse owned jointly or which was marital property at any time during their marriage regardless of the form of ownership and regardless of whether it was owned or titled in the names of one or both the recipient and the recipient's spouse. Title and interest in the property of a predeceased recipient spouse shall not end or extinguish upon the person's death and shall continue for the purpose of allowing recovery of medical assistance in the estate of the surviving spouse. Upon the death of the predeceased recipient spouse, title and interest in the predeceased spouse's property shall vest in the surviving spouse by operation of law and without the necessity for any probate or decree of descent proceedings and shall continue to exist after the death of the predeceased spouse and the surviving spouse to permit recovery of medical assistance. The recipient spouse and the surviving spouse of a deceased recipient spouse shall not encumber, disclaim, transfer, alienate, hypothecate, or otherwise divest themselves of these interests before or upon death.

(c) For purposes of this section, "marital property" includes any and all real or personal property of any kind or interests in such property the predeceased recipient spouse and their spouse, or either of them, owned at the time of their marriage to each other or acquired during their marriage regardless of whether it was owned or titled in the names of one or both of them. If either or both spouses of a married couple received medical assistance, all property owned during the marriage or which either or both spouses acquired during their marriage shall be presumed to be marital property for purposes of recovering medical assistance unless there is clear and convincing evidence to the contrary.

(d) The agency responsible for the claim for medical assistance for a recipient spouse may, at its discretion, release specific real and personal property from the provisions of this section. The release shall extinguish the interest created under paragraph (b) in the land it describes upon filing or recording. The release need not be attested, certified, or acknowledged as a condition of filing or recording and shall be filed or recorded in the office of the county recorder or registrar of titles, as appropriate, in the county where the real property is located. The party to whom the release is given shall be responsible for paying all fees and costs necessary to record and file the release. If the property described in the release is registered property, the registrar of titles shall accept it for recording and shall record it on the certificate of title for each parcel of property described in the release. If the property described in the release is abstract property, the recorder shall accept it for filing and file it in the county's grantor-grantee indexes and any tract index the county maintains for each parcel of property described in the release.

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Subd. 3. **Surviving spouse, minor, blind, or disabled children.** If a decedent is survived by a spouse, or was single or the surviving spouse of a married couple and is survived by a child who is under age 21 or blind or permanently and totally disabled according to the Supplemental Security Income program criteria, a claim shall be filed against the estate according to this section.

Subd. 4. **Other survivors.** (a) If the decedent who was single or the surviving spouse of a married couple is survived by one of the following persons, a claim exists against the estate payable first from the value of the nonhomestead property included in the estate and the personal representative shall make, execute, and deliver to the county agency a lien against the homestead property in the estate for any unpaid balance of the claim to the claimant as provided under this section:

(1) a sibling who resided in the decedent medical assistance recipient's home at least one year before the decedent's institutionalization and continuously since the date of institutionalization; or

(2) a son or daughter or a grandchild who resided in the decedent medical assistance recipient's home for at least two years immediately before the parent's or grandparent's institutionalization and continuously since the date of institutionalization, and who establishes by a preponderance of the evidence having provided care to the parent or grandparent who received medical assistance, that the care was provided before institutionalization, and that the care permitted the parent or grandparent to reside at home rather than in an institution.

(b) For purposes of this subdivision, "institutionalization" means receiving care:

(1) in a nursing facility or swing bed, or intermediate care facility for persons with developmental disabilities; or

(2) through home and community-based services under section 256B.0915, 256B.092, or 256B.49.

Subd. 5. **Undue hardship.** (a) Any person entitled to notice in subdivision 1a has a right to apply for waiver of the claim based upon undue hardship. Any claim pursuant to this section may be fully or partially waived because of undue hardship. Undue hardship does not include action taken by the decedent which divested or diverted assets in order to avoid estate recovery. Any waiver of a claim must benefit the person claiming undue hardship. The commissioner shall have authority to hear claimant appeals, pursuant to section 256.045, when an application for a hardship waiver is denied in whole or part.

(b) Upon approval of a hardship waiver, this paragraph applies to a claim against the decedent's real property if an individual other than the recipient's spouse had an ownership interest in the property at the time of the decedent's death and actually and continuously occupied the real property as the individual's residence for at least 180 days before the date the decedent died. If the real property is classified as the individual's homestead property for property tax purposes under section 273.124, no adjustment or recovery may be made until the individual no longer resides in the property or until the property is sold or transferred.

Subd. 6. **Life estate or joint tenancy interest.** For purposes of subdivision 1 and section 514.981, subdivision 6, a life estate or joint tenancy interest is established upon the earlier of:

(1) the date the instrument creating the interest is recorded or filed in the office of the county recorder or registrar of titles where the real estate interest it describes is located;

(2) the date of delivery by the grantor to the grantee of the signed instrument as stated in an affidavit made by a person with knowledge of the facts;

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(3) the date on which the judicial order creating the interest was issued by the court; or

(4) the date upon which the interest devolves under section 524.3-101.

Subd. 7. **Lien notices.** Medical assistance liens and liens under notices of potential claims that are of record against life estate or joint tenancy interests established prior to August 1, 2003, shall end, become unenforceable, and cease to be liens on those interests upon the death of the person named in the lien or notice of potential claim, shall be disregarded by examiners of title after the death of the life tenant or joint tenant, and shall not be carried forward to a subsequent certificate of title. This subdivision shall not apply to life estates that continue to exist after the death of the person named in the lien or notice of potential claim under the terms of the instrument creating or reserving the life estate until the life estate ends as provided for in the instrument.

Subd. 8. **Immunity.** The commissioner of human services, county agencies, and elected officials and their employees are immune from all liability for any action taken implementing Laws 2003, First Special Session chapter 14, article 12, sections 40 to 52 and 90, as those laws existed at the time the action was taken, and section 514.981, subdivision 6.

Subd. 9. **Commissioner's intervention.** The commissioner shall be permitted to intervene as a party in any proceeding involving recovery of medical assistance upon filing a notice of intervention and serving such notice on the other parties.

History: *Ex1967 c 16 s 15; 1981 c 360 art 1 s 22; 1Sp1981 c 4 art 1 s 126; 1986 c 444; 1987 c 403 art 2 s 82; 1988 c 719 art 8 s 15; 1990 c 568 art 3 s 63; 1992 c 513 art 7 s 80,81; 1Sp1993 c 1 art 5 s 82,83; 1995 c 207 art 6 s 79-81; 1996 c 451 art 2 s 29,30,61,62; art 5 s 26; 2000 c 400 s 2,3; 2001 c 203 s 17; 1Sp2003 c 14 art 2 s 27-29; art 12 s 40-52; 2005 c 56 s 1; 1Sp2005 c 4 art 7 s 28-32; 2008 c 326 art 1 s 34; 2008 c 341 art 2 s 1,2; 2009 c 79 art 5 s 38-43; 2009 c 160 s 1,2; 2012 c 216 art 11 s 36,37*

NOTE: The amendments to subdivisions 1a and 2 by Laws 1995, chapter 207, article 6, sections 79 and 80, relating only to the age of a medical assistance recipient for purposes of estate claims, are effective for persons who are between the ages of 55 and 64 on or after July 1, 1995, for the total amount of assistance on or after July 1, 1995. See Laws 1995, chapter 207, article 6, section 125, subdivision 1.

NOTE: Subdivision 2 (Minnesota Statutes 2008) was held preempted by federal law to the extent it allows recovery against the estate of a surviving spouse of a Medicaid recipient from assets in which the deceased Medicaid recipient did not have a legal interest at the time of death. In re Estate of Barg, 752 N.W.2d 52 (Minn. 2008), cert. denied Vos v. Barg, 129 S.Ct. 2859 (2009). See Laws 2009, chapter 79, article 5, sections 38 to 43. Centers for Medicare and Medicaid Services approved state plan amendment effective July 1, 2009.

256B.16 [Repealed, 1971 c 550 s 2]

256B.17 TRANSFERS OF PROPERTY.

Subdivision 1. [Repealed, 1997 c 107 s 19]

Subd. 2. [Repealed, 1997 c 107 s 19]

Subd. 3. [Repealed, 1997 c 107 s 19]

Subd. 4. [Repealed, 1997 c 107 s 19]

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Subd. 5. [Repealed, 1997 c 107 s 19]

Subd. 6. [Repealed, 1997 c 107 s 19]

Subd. 7. **Exception for asset transfers.** An institutionalized spouse, institutionalized before October 1, 1989, for a continuous period, who applies for medical assistance on or after July 1, 1983, may transfer liquid assets to a noninstitutionalized spouse if all of the following conditions apply:

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

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

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

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

Subd. 8. [Repealed, 1997 c 107 s 19]

History: *Ex1967 c 16 s 17; 1981 c 360 art 2 s 30; 1983 c 312 art 5 s 20-24; 1984 c 534 s 23; 1985 c 252 s 23; 1986 c 444; 1987 c 403 art 2 s 83,84; 1988 c 689 art 2 s 151,268; 1989 c 282 art 3 s 98; 1990 c 568 art 3 s 95,96; 1997 c 107 s 7*

256B.18 METHODS OF ADMINISTRATION.

The state agency shall prescribe such methods of administration as are necessary for compliance with requirements of the Social Security Act, as amended, and for the proper and efficient operation of the program of assistance hereunder. The state agency shall establish and maintain a system of personnel standards on a merit basis for all such employees of the county agencies and the examination thereof, and the administration thereof shall be directed and controlled exclusively by the state agency except in those counties in which such employees are covered by a merit system that meets the requirements of the state agency and the Social Security Act, as amended.

History: *Ex1967 c 16 s 18*

256B.19 DIVISION OF COST.

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

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

(2) beginning January 1, 2003, 80 percent state funds and 20 percent county funds for the costs of nursing facility placements of persons with disabilities under the age of 65 that have exceeded 90 days. This clause shall be subject to chapter 256G and shall not apply to placements in facilities not certified to participate in medical assistance;

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(3) beginning July 1, 2004, 90 percent state funds and ten percent county funds for the costs of placements that have exceeded 90 days in intermediate care facilities for persons with developmental disabilities that have seven or more beds. This provision includes pass-through payments made under section 256B.5015; and

(4) beginning July 1, 2004, when state funds are used to pay for a nursing facility placement due to the facility's status as an institution for mental diseases (IMD), the county shall pay 20 percent of the nonfederal share of costs that have exceeded 90 days. This clause is subject to chapter 256G.

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

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

Subd. 1a. [Repealed, 2002 c 277 s 34]

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

Subd. 1c. **Additional portion of nonfederal share.** (a) Hennepin County shall be responsible for a monthly transfer payment of $1,500,000, due before noon on the 15th of each month and the University of Minnesota shall be responsible for a monthly transfer payment of $500,000 due before noon on the 15th of each month, beginning July 15, 1995. These sums shall be part of the designated governmental unit's portion of the nonfederal share of medical assistance costs.

(b) Beginning July 1, 2001, Hennepin County's payment under paragraph (a) shall be $2,066,000 each month.

(c) Beginning July 1, 2001, the commissioner shall increase annual capitation payments to a demonstration provider serving eligible individuals in Hennepin County under section 256B.69 for the prepaid medical assistance program by approximately $6,800,000 to recognize higher than average medical education costs.

(d) Effective August 1, 2005, Hennepin County's payment under paragraphs (a) and (b) shall be reduced to $566,000, and the University of Minnesota's payment under paragraph (a) shall be reduced to zero. Effective October 1, 2008, to December 31, 2010, Hennepin County's payment under paragraphs (a) and (b) shall be $434,688. Effective January 1, 2011, Hennepin County's payment under paragraphs (a) and (b) shall be $566,000.

(e) Notwithstanding paragraph (d), upon federal enactment of an extension to June 30, 2011, of the enhanced federal medical assistance percentage (FMAP) originally provided under Public Law 111-5, for the six-month period from January 1, 2011, to June 30, 2011, Hennepin County's payment under paragraphs (a) and (b) shall be $434,688.

Subd. 1d. [Repealed, 2009 c 79 art 8 s 86]

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Subd. 1e. **Additional local share of certain nursing facility costs.** Beginning October 1, 2011, participating local governmental entities that own the physical plant or are the license holders of nursing facilities receiving rate adjustments under section 256B.441, subdivision 55a, shall be responsible for paying the portion of nonfederal costs calculated under section 256B.441, subdivision 55a, paragraph (e). Payments of the nonfederal share shall be submitted to the commissioner by the 15th day of the month prior to payment to the nursing facility for that month's services. If any participating governmental entity obligated to pay an amount under this subdivision does not make timely payment of the monthly installment, the commissioner shall revoke participation under this subdivision and end payments determined under section 256B.441, subdivision 55a, to the participating nursing facility effective on the first day of the month for which timely payment was not received. In the event of revocation, the nursing facility may not bill, collect, or retain the amount allowed in section 256B.441, subdivision 55a, from private-pay residents for days of service on or after the first day of the month following the month in which the revocation occurred.

Subd. 2. **Distribution of federal funds.** Federal funds available for administrative purposes shall be distributed between the state and the county in the same proportion that expenditures were made, except as provided for in section 256.017.

Subd. 2a. **Division of costs.** The county shall ensure that only the least costly, most appropriate transportation and travel expenses are used. The state may enter into volume purchase contracts, or use a competitive bidding process, whenever feasible, to minimize the costs of transportation services. If the state has entered into a volume purchase contract or used the competitive bidding procedures of chapter 16C to arrange for transportation services, the county may be required to use such arrangements.

Subd. 2b. **Pilot project reimbursement.** In counties where a pilot or demonstration project is operated under the medical assistance program, the state may pay 100 percent of the administrative costs for the pilot or demonstration project after June 30, 1990.

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

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

(c) For general assistance medical care recipients and MinnesotaCare program enrollees, if the local agency fails to comply with paragraph (a), the local agency is responsible for the entire cost of general assistance medical care or MinnesotaCare program services provided from the date the commissioner issues the notice until the date the local agency takes appropriate action on the case and notifies the commissioner of the action. For infants, if the local agency fails to comply with paragraph (b), the commissioner may determine eligibility for medical assistance for the infant for a period of two months, and the local agency shall be responsible for the entire cost of medical assistance services provided for that infant, in addition

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to a fee of $100 for processing the case. The commissioner shall deduct any obligation incurred under this paragraph from the amount due to the local agency under subdivision 1.

Subd. 3. [Repealed, 2014 c 262 art 2 s 18]

History: *Ex1967 c 16 s 19; 1971 c 547 s 1; 1975 c 437 art 2 s 7; 1982 c 640 s 7; 1983 c 312 art 9 s 6; 1984 c 534 s 24; 1Sp1985 c 9 art 2 s 46; 1986 c 444; 1987 c 403 art 2 s 85; 1988 c 719 art 8 s 16,17; 1Sp1989 c 1 art 16 s 8,9; 1990 c 568 art 3 s 64; 1991 c 292 art 4 s 51-53; 1992 c 513 art 7 s 82; 1993 c 13 art 1 s 32; 1Sp1993 c 1 art 5 s 84-86; 1995 c 207 art 6 s 82-84; 1995 c 234 art 8 s 56; 1997 c 203 art 11 s 7; 1998 c 386 art 2 s 80; 1Sp2001 c 9 art 2 s 45; 2002 c 220 art 14 s 7,8; 2002 c 277 s 20-23; 2002 c 375 art 2 s 34; 2002 c 379 art 1 s 113; 2003 c 9 s 1; 1Sp2003 c 14 art 3 s 43; 2005 c 56 s 1; 1Sp2005 c 4 art 2 s 14; art 8 s 48; 2008 c 363 art 15 s 8; 2010 c 396 s 4; 1Sp2010 c 1 art 24 s 6; 1Sp2011 c 9 art 7 s 24; 2012 c 216 art 13 s 14*

256B.194 FEDERAL PAYMENTS.

The commissioner may require medical assistance and MinnesotaCare providers to provide any information necessary to determine Medicaid-related costs, and require the cooperation of providers in any audit or review necessary to ensure payments are limited to cost. This section does not apply to providers who are exempt from the provisions of the CMS final rule, published May 29, 2007, at Federal Register, Vol. 72, No. 100, governing payments to providers that are units of government. This section becomes effective when the CMS final rule goes into effect at the end of the moratorium imposed by Congress.

History: *2008 c 363 art 17 s 12*

256B.195 [Repealed, 2010 c 200 art 1 s 21]

256B.196 INTERGOVERNMENTAL TRANSFERS; HOSPITAL PAYMENTS.

Subdivision 1. **Federal approval required.** This section is contingent on federal approval of the intergovernmental transfers and payments authorized under this section. This section is also contingent on current payment by the government entities of the intergovernmental transfers under this section.

Subd. 2. **Commissioner's duties.** (a) For the purposes of this subdivision and subdivision 3, the commissioner shall determine the fee-for-service outpatient hospital services upper payment limit for nonstate government hospitals. The commissioner shall then determine the amount of a supplemental payment to Hennepin County Medical Center and Regions Hospital for these services that would increase medical assistance spending in this category to the aggregate upper payment limit for all nonstate government hospitals in Minnesota. In making this determination, the commissioner shall allot the available increases between Hennepin County Medical Center and Regions Hospital based on the ratio of medical assistance fee-for-service outpatient hospital payments to the two facilities. The commissioner shall adjust this allotment as necessary based on federal approvals, the amount of intergovernmental transfers received from Hennepin and Ramsey Counties, and other factors, in order to maximize the additional total payments. The commissioner shall inform Hennepin County and Ramsey County of the periodic intergovernmental transfers necessary to match federal Medicaid payments available under this subdivision in order to make supplementary medical assistance payments to Hennepin County Medical Center and Regions Hospital equal to an amount that when combined with existing medical assistance payments to nonstate governmental hospitals would increase total payments to hospitals in this category for outpatient services to the aggregate upper payment limit for all hospitals in this category in Minnesota. Upon receipt of these periodic transfers,

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the commissioner shall make supplementary payments to Hennepin County Medical Center and Regions Hospital.

(b) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for physicians and other billing professionals affiliated with Hennepin County Medical Center and with Regions Hospital. The upper payment limit shall be based on the average commercial rate or be determined using another method acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall inform Hennepin County and Ramsey County of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to physicians and other billing professionals affiliated with Hennepin County Medical Center and to make supplementary payments to physicians and other billing professionals affiliated with Regions Hospital through HealthPartners Medical Group equal to the difference between the established medical assistance payment for physician and other billing professional services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to physicians and other billing professionals affiliated with Hennepin County Medical Center and shall make supplementary payments to physicians and other billing professionals affiliated with Regions Hospital through HealthPartners Medical Group.

(c) Beginning January 1, 2010, Hennepin County and Ramsey County may make monthly voluntary intergovernmental transfers to the commissioner in amounts not to exceed $12,000,000 per year from Hennepin County and $6,000,000 per year from Ramsey County. The commissioner shall increase the medical assistance capitation payments to any licensed health plan under contract with the medical assistance program that agrees to make enhanced payments to Hennepin County Medical Center or Regions Hospital. The increase shall be in an amount equal to the annual value of the monthly transfers plus federal financial participation, with each health plan receiving its pro rata share of the increase based on the pro rata share of medical assistance admissions to Hennepin County Medical Center and Regions Hospital by those plans. Upon the request of the commissioner, health plans shall submit individual-level cost data for verification purposes. The commissioner may ratably reduce these payments on a pro rata basis in order to satisfy federal requirements for actuarial soundness. If payments are reduced, transfers shall be reduced accordingly. Any licensed health plan that receives increased medical assistance capitation payments under the intergovernmental transfer described in this paragraph shall increase its medical assistance payments to Hennepin County Medical Center and Regions Hospital by the same amount as the increased payments received in the capitation payment described in this paragraph.

(d) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for ambulance services affiliated with Hennepin County Medical Center and the city of St. Paul. The upper payment limit shall be based on the average commercial rate or be determined using another method acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall inform Hennepin County and the city of St. Paul of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to Hennepin County Medical Center and the city of St. Paul equal to the difference between the established medical assistance payment for ambulance services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to Hennepin County Medical Center and the city of St. Paul.

(e) The commissioner shall inform the transferring governmental entities on an ongoing basis of the need for any changes needed in the intergovernmental transfers in order to continue the payments under paragraphs (a) to (d), at their maximum level, including increases in upper payment limits, changes in the federal Medicaid match, and other factors.

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(f) The payments in paragraphs (a) to (d) shall be implemented independently of each other, subject to federal approval and to the receipt of transfers under subdivision 3.

Subd. 3. **Intergovernmental transfers.** Based on the determination by the commissioner under subdivision 2, Hennepin County and Ramsey County shall make periodic intergovernmental transfers to the commissioner for the purposes of subdivision 2, paragraphs (a) and (b). All of the intergovernmental transfers made by Hennepin County shall be used to match federal payments to Hennepin County Medical Center under subdivision 2, paragraph (a), and to physicians and other billing professionals affiliated with Hennepin County Medical Center under subdivision 2, paragraph (b). All of the intergovernmental transfers made by Ramsey County shall be used to match federal payments to Regions Hospital under subdivision 2, paragraph (a), and to physicians and other billing professionals affiliated with Regions Hospital through HealthPartners Medical Group under subdivision 2, paragraph (b).

Subd. 4. **Adjustments permitted.** (a) The commissioner may adjust the intergovernmental transfers under subdivision 3 and the payments under subdivision 2, based on the commissioner's determination of Medicare upper payment limits, hospital-specific charge limits, hospital-specific limitations on disproportionate share payments, medical inflation, actuarial certification, and cost-effectiveness for purposes of federal waivers. Any adjustments must be made on a proportional basis. The commissioner may make adjustments under this subdivision only after consultation with the affected counties and hospitals. All payments under subdivision 2 and all intergovernmental transfers under subdivision 3 are limited to amounts available after all other base rates, adjustments, and supplemental payments in chapter 256B are calculated.

(b) The ratio of medical assistance payments specified in subdivision 2 to the voluntary intergovernmental transfers specified in subdivision 3 shall not be reduced except as provided under paragraph (a).

Subd. 5. **Recession period.** Each type of intergovernmental transfer in subdivision 2, paragraphs (a) to (d), for payment periods from October 1, 2008, through June 30, 2013, is voluntary on the part of Hennepin and Ramsey Counties, meaning that the transfer must be agreed to, in writing, by the counties prior to any payments being issued. One agreement on each type of transfer shall cover the entire recession period.

History: *2009 c 79 art 5 s 44; 2010 c 200 art 1 s 8; 1Sp2011 c 9 art 6 s 56-58; 2013 c 108 art 6 s 19*

256B.197 INTERGOVERNMENTAL TRANSFERS; INPATIENT HOSPITAL PAYMENTS.

Subdivision 1. **Federal approval required.** This section is effective for federal fiscal year 2010 and future years contingent on federal approval of the voluntary intergovernmental transfers and payments authorized under this section and contingent on payment of the intergovernmental transfers under this section.

Subd. 2. **Eligible nonstate government hospitals.** (a) Hennepin County Medical Center and Regions Hospital are eligible nonstate government hospitals.

(b) If the commissioner obtains federal approval to include other hospitals, including University of Minnesota Medical Center, Fairview, and SMDC Medical Center, the commissioner may expand the definition of eligible nonstate government hospitals to include other hospitals.

Subd. 3. **Commissioner's duties.** (a) For the purposes of this subdivision, the commissioner shall determine the fee-for-service inpatient hospital services upper payment limit for nonstate government hospitals. The commissioner shall determine, for each eligible nonstate government hospital, the amount of a supplemental payment for inpatient hospital services that would increase medical assistance spending for each eligible nonstate government hospital up to the amount that Medicare would pay for the Medicaid

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fee-for-service inpatient hospital services provided by that hospital. If the combined amount of such supplemental payment amounts and existing medical assistance payments for inpatient hospital services to all nonstate government hospitals is less than the upper payment limit, the commissioner shall increase the supplemental payment amount for each eligible nonstate government hospital in proportion to the initial supplemental payments in order to maximize the additional total payments.

(b) The commissioner shall inform each eligible nonstate government hospital and associated governmental entities of voluntary intergovernmental transfers necessary to provide the nonfederal share for the supplemental payment amount attributable to each eligible nonstate government hospital, as calculated under paragraph (a).

(c) Upon receipt of a voluntary intergovernmental transfer from a governmental entity associated with an eligible nonstate government hospital or from the eligible nonstate government hospital, the commissioner shall make a supplemental payment, using the amounts calculated under paragraph (a), to the associated eligible nonstate government hospital.

(d) The commissioner may implement the payments in this section through use of periodic payments and voluntary intergovernmental transfers.

(e) The commissioner shall inform eligible nonstate government hospitals and associated governmental entities on an ongoing basis of the need for any changes needed in the payment amounts or voluntary intergovernmental transfers in order to continue the payments under paragraph (c) at their maximum level, including increases in upper payment limits, changes in the federal Medicaid match, and other factors.

History: *2010 c 200 art 1 s 9*

256B.198 PAYMENTS FOR NON-HOSPITAL-BASED GOVERNMENTAL HEALTH CENTERS.

(a) The commissioner may make payments to non-hospital-based health centers operated by a governmental entity for the difference between the expenditures incurred by the health center for patients eligible for medical assistance, and the payments to the health center for medical assistance permitted elsewhere under this chapter.

(b) The nonfederal share of payments authorized under paragraph (a) shall be provided through certified public expenditures authorized under section 256B.199, paragraph (b).

(c) Effective July 1, 2013, or no earlier than 12 months after implementation of a total cost of care demonstration project, Hennepin County may receive federal matching funds for certified public expenditures under paragraph (a), if the county participates in a total cost of care demonstration project under sections 256B.0755 and 256B.0756, or another total cost of care demonstration project approved by the commissioner, and the county exceeds the minimum performance threshold established by the commissioner for the demonstration project. The value of the federal matching funds for the certified public expenditures allocated to Hennepin County shall be equal to the value of savings achieved above the minimum performance threshold. The same proportion of federal matching funds for certified public expenditure allocated to Hennepin County based on savings achieved under the demonstration project shall continue after the demonstration project and must continue to be paid to Hennepin County each year thereafter.

(d) Beginning July 1, 2014, or no earlier than 12 months after the initial allocation under paragraph (c) if a portion of the federal matching funds for certified public expenditure remains with the state, the commissioner shall annually determine if the savings from county's total cost of care demonstration project

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exceeded the savings from the previous year and allocate federal matching funds for certified public expenditures to Hennepin County equal to the amount of savings achieved above the amount achieved in the previous year. The proportion of federal matching funds for certified public expenditure allocated to Hennepin County shall be paid to Hennepin County each year thereafter, until no federal matching funds for certified public expenditures under paragraph (a) remain with the state.

(e) Nothing under this section precludes Hennepin County from receiving an additional gain-sharing payment or relieves the county from paying a downside risk-sharing payment to the state under the demonstration project under section 256B.0755.

History: *1Sp2011 c 9 art 6 s 59*

256B.199 PAYMENTS REPORTED BY GOVERNMENTAL ENTITIES.

(a) The commissioner shall apply for federal matching funds for the expenditures in paragraphs (b) and (c).

(b) The commissioner shall apply for federal matching funds for certified public expenditures as follows:

(1) Hennepin County, Hennepin County Medical Center, Ramsey County, and Regions Hospital shall report quarterly to the commissioner beginning June 1, 2007, payments made during the second previous quarter that may qualify for reimbursement under federal law;

(2) based on these reports, the commissioner shall apply for federal matching funds; and

(3) by May 1 of each year, beginning May 1, 2007, the commissioner shall inform the nonstate entities listed in paragraph (a) of the amount of federal disproportionate share hospital payment money expected to be available in the current federal fiscal year.

(c) For the period from April 1, 2009, to September 30, 2010, the commissioner shall apply for additional federal matching funds available as disproportionate share hospital payments under the American Recovery and Reinvestment Act of 2009. These funds shall be made available as the state share of payments. The entities required to report certified public expenditures under paragraph (b), clause (1), shall report additional certified public expenditures as necessary under this paragraph.

(d) For services provided on or after September 1, 2011, the commissioner shall apply for additional federal matching funds available as disproportionate share hospital payments under the MinnesotaCare program. A hospital may elect on an annual basis to not be a disproportionate share hospital for purposes of this paragraph, if the hospital does not qualify for a payment under section 256.969, subdivision 9, paragraph (b).

History: *1Sp2005 c 4 art 8 s 50; 2007 c 147 art 5 s 13; 2009 c 79 art 5 s 45; 1Sp2011 c 9 art 6 s 60; 2014 c 312 art 24 s 37*

256B.20 COUNTY APPROPRIATIONS.

The providing of funds necessary to carry out the provisions hereof on the part of the counties and the manner of administering the funds of the counties and the state shall be as follows:

(1) The board of county commissioners of each county shall annually set up in its budget an item designated as the county medical assistance fund and levy taxes and fix a rate therefor sufficient to produce

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the full amount of such item, in addition to all other tax levies and tax rate, however fixed or determined, sufficient to carry out the provisions hereof and sufficient to pay in full the county share of assistance and administrative expense for the ensuing year; and annually on or before October 10 shall certify the same to the county auditor to be entered by the auditor on the tax rolls. Such tax levy and tax rate shall make proper allowance and provision for shortage in tax collections.

(2) Any county may transfer surplus funds from any county fund, except the sinking or ditch fund, to the general fund or to the county medical assistance fund in order to provide money necessary to pay medical assistance awarded hereunder. The money so transferred shall be used for no other purpose, but any portion thereof no longer needed for such purpose shall be transferred back to the fund from which taken.

(3) Upon the order of the county agency the county auditor shall draw a warrant on the proper fund in accordance with the order, and the county treasurer shall pay out the amounts ordered to be paid out as medical assistance hereunder. When necessary by reason of failure to levy sufficient taxes for the payment of the medical assistance in the county, the county auditor shall carry any such payments as an overdraft on the medical assistance funds of the county until sufficient tax funds shall be provided for such assistance payments. The board of county commissioners shall include in the tax levy and tax rate in the year following the year in which such overdraft occurred, an amount sufficient to liquidate such overdraft in full.

(4) Claims for reimbursement and reports shall be presented to the state agency by the respective counties as required under section 256.01, subdivision 2, paragraph (17). The state agency shall audit such claims and certify to the commissioner of management and budget the amounts due the respective counties without delay. The amounts so certified shall be paid within ten days after such certification, from the state treasury upon warrant of the commissioner of management and budget from any money available therefor. The money available to the state agency to carry out the provisions hereof, including all federal funds available to the state, shall be kept and deposited by the commissioner of management and budget in the revenue fund and disbursed upon warrants in the same manner as other state funds.

History: *Ex1967 c 16 s 20; 1973 c 492 s 14; 1986 c 444; 1989 c 89 s 11; 2003 c 112 art 2 s 50; 2009 c 101 art 2 s 109*

256B.21 CHANGE OF RESIDENCE.

On changing residence, a recipient shall notify the county agency through which the recipient's medical assistance hereunder is paid. On removing to another county, the recipient shall declare whether such absence is temporary or for the purpose of residing therein.

History: *Ex1967 c 16 s 21; 1986 c 444*

256B.22 COMPLIANCE WITH SOCIAL SECURITY ACT.

The various terms and provisions hereof, including the amount of medical assistance paid hereunder, are intended to comply with and give effect to the program set out in title XIX of the federal Social Security Act. During any period when federal funds shall not be available or shall be inadequate to pay in full the federal share of medical assistance as defined in title XIX of the federal Social Security Act, as amended by Public Law 92-603, the state may reduce by an amount equal to such deficiency the payments it would otherwise be obligated to make pursuant to section 256B.041.

History: *Ex1967 c 16 s 22; 1973 c 717 s 20*

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256B.23 USE OF FEDERAL FUNDS.

All federal funds made available for the purposes hereof are hereby appropriated to the state agency to be disbursed and paid out in accordance with the provisions hereof.

History: *Ex1967 c 16 s 23*

256B.24 PROHIBITIONS.

No enrollment fee, premium, or similar charge shall be required as a condition of eligibility for medical assistance hereunder.

History: *Ex1967 c 16 s 24*

256B.25 PAYMENTS TO CERTIFIED FACILITIES.

Subdivision 1. **Licensing required.** Payments may not be made hereunder for care in any private or public institution, including but not limited to hospitals and nursing homes, unless licensed by an appropriate licensing authority of this state, any other state, or a Canadian province and if applicable, certified by an appropriate authority under United States Code, title 42, sections 1396-1396p.

Subd. 2. **Payment distribution.** The payment of state or county funds to nursing homes, boarding care homes, and supervised living facilities, except payments to state operated institutions, for the care of persons who are eligible for medical assistance, shall be made only through the medical assistance program, except as provided in subdivision 3.

Subd. 3. **Payment exceptions.** The limitation in subdivision 2 shall not apply to:

(a) payment of Minnesota supplemental assistance funds to recipients who reside in facilities which are involved in litigation contesting their designation as an institution for treatment of mental disease;

(b) payment or grants to a boarding care home or supervised living facility licensed by the Department of Human Services under Minnesota Rules, parts 9520.0500 to 9520.0690, 9530.2500 to 9530.4000, 9545.0900 to 9545.1090, or 9545.1400 to 9545.1500, or payment to recipients who reside in these facilities;

(c) payments or grants to a boarding care home or supervised living facility which are ineligible for certification under United States Code, title 42, sections 1396-1396p;

(d) payments or grants otherwise specifically authorized by statute or rule.

Subd. 4. **Payment during suspended admissions.** A nursing home or boarding care home that has received a notice to suspend admissions under section 144A.10, subdivision 4a, shall be ineligible to receive payment for admissions that occur during the effective dates of the suspension. Upon termination of the suspension by the commissioner of health, payments may be made for eligible persons, beginning with the day after the suspension ends.

History: *Ex1967 c 16 s 25; 1969 c 395 s 2; 1984 c 641 s 13; 1984 c 654 art 5 s 58; 1985 c 248 s 69; 1989 c 282 art 3 s 64*

256B.26 AGREEMENTS WITH OTHER STATE DEPARTMENTS.

The commissioner of the Department of Human Services is authorized to enter into cooperative agreements with other state departments or divisions of this state or of other states responsible for admin-

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istering or supervising the administration of health services and vocational rehabilitation services in the state for maximum utilization of such service in the provision of medical assistance under sections 256B.01 to 256B.26.

History: *Ex1967 c 16 s 26; 1984 c 654 art 5 s 58*

256B.27 MEDICAL ASSISTANCE; COST REPORTS.

Subdivision 1. **Reports and audits.** In the interests of efficient administration of the medical assistance to the needy program and incident to the approval of rates and charges therefor, the commissioner of human services may require any reports, information, and audits of medical vendors which the commissioner deems necessary.

Subd. 2. **Verification of report.** All reports as to the costs of operations or of medical care provided which are submitted by vendors of medical care for use in determining their rates or reimbursement shall be submitted under oath as to the truthfulness of their contents by the vendor or an officer or authorized representative of the vendor.

Subd. 2a. **Cost and statistical data audits.** The commissioner shall provide for an audit of the cost and statistical data of nursing facilities participating as vendors of medical assistance. The commissioner shall select for audit at least 15 percent of the nursing facilities' data reported at random or using factors including, but not limited to: data reported to the public as criteria for rating nursing facilities; data used to set limits for other medical assistance programs or vendors of services to nursing facilities; change in ownership; frequent changes in administration in excess of normal turnover rates; complaints to the commissioner of health about care, safety, or rights; where previous inspections or reinspections under section 144A.10 have resulted in correction orders related to care, safety, or rights; or where persons involved in ownership or administration of the facility have been indicted for alleged criminal activity.

The commissioner shall meet the 15 percent requirement by either conducting an audit focused on an individual nursing facility, a group of facilities, or targeting specific data categories in multiple nursing facilities. These audits may be conducted on site at the nursing facility, at office space used by a nursing facility or a nursing facility's parent organization, or at the commissioner's office. Data being audited may be collected electronically, in person, or by any other means the commissioner finds acceptable.

Subd. 3. **Access to medical records.** The commissioner of human services, with the written consent of the recipient, on file with the local welfare agency, shall be allowed access to all personal medical records of medical assistance recipients solely for the purposes of investigating whether or not: (a) a vendor of medical care has submitted a claim for reimbursement, a cost report or a rate application which is duplicative, erroneous, or false in whole or in part, or which results in the vendor obtaining greater compensation than the vendor is legally entitled to; or (b) the medical care was medically necessary. The vendor of medical care shall receive notification from the commissioner at least 24 hours before the commissioner gains access to such records. The determination of provision of services not medically necessary shall be made by the commissioner. Notwithstanding any other law to the contrary, a vendor of medical care shall not be subject to any civil or criminal liability for providing access to medical records to the commissioner of human services pursuant to this section.

Subd. 4. **Authorization of commissioner to examine records.** A person determined to be eligible for medical assistance shall be deemed to have authorized the commissioner of human services in writing to examine, for the investigative purposes identified in subdivision 3, all personal medical records developed while receiving medical assistance.

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Subd. 5. **Private data.** Medical records obtained by the commissioner of human services pursuant to this section are private data, as defined in section 13.02, subdivision 12.

History: *1971 c 961 s 24; 1976 c 188 s 3; 1977 c 326 s 11; 1980 c 349 s 7,8; 1981 c 311 s 39; 1982 c 476 s 1; 1982 c 545 s 24; 1982 c 640 s 8; 1983 c 312 art 5 s 25,26; 1984 c 654 art 5 s 58; 1986 c 444; 1987 c 370 art 1 s 5,6; 1988 c 629 s 53; 1995 c 207 art 11 s 6; 2007 c 147 art 6 s 40; 2014 c 286 art 7 s 11*

256B.30 HEALTH CARE FACILITY REPORT.

Every facility required to be licensed under the provisions of sections 144.50 to 144.58, or 144A.02, shall provide annually to the commissioner of human services the reports as may be required under law and under rules adopted by the commissioner of human services under the Administrative Procedure Act. The rules shall provide for the submission of a full and complete financial report of a facility's operations including:

(1) An annual statement of income and expenditures;

(2) A complete statement of fees and charges;

(3) The names of all persons other than mortgage companies owning any interest in the facility including stockholders with an ownership interest of ten percent or more of the facility.

The financial reports and supporting data of the facility shall be available for inspection and audit by the commissioner of human services.

History: *1973 c 688 s 8; 1976 c 173 c 57; 1984 c 654 art 5 s 58*

256B.31 [Repealed, 2014 c 262 art 4 s 9]

256B.32 FACILITY FEE PAYMENT.

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

(b) For fee-for-service services provided on or after July 1, 2002, the total payment, before third-party liability and spenddown, made to hospitals for outpatient hospital facility services is reduced by .5 percent from the current statutory rates.

(c) In addition to the reduction in paragraph (b), the total payment for fee-for-service services provided on or after July 1, 2003, made to hospitals for outpatient hospital facility services before third-party liability and spenddown, is reduced five percent from the current statutory rates. Facilities defined under section 256.969, subdivision 16, are excluded from this paragraph.

(d) In addition to the reductions in paragraphs (b) and (c), the total payment for fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient hospital facility services before third-party

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liability and spenddown, is reduced three percent from the current statutory rates. Mental health services and facilities defined under section 256.969, subdivision 16, are excluded from this paragraph.

Subd. 2. **Prospective payment system.** Effective for services provided on or after July 1, 2003, rates that are based on the Medicare outpatient prospective payment system shall be replaced by a budget-neutral prospective payment system that is derived using medical assistance data.

History: *1989 c 285 s 4; 2002 c 220 art 15 s 14; 2002 c 275 s 4; 1Sp2003 c 14 art 12 s 55; 2008 c 363 art 17 s 13*

256B.35 PERSONAL NEEDS ALLOWANCE; PERSONS IN CERTAIN FACILITIES.

Subdivision 1. **Personal needs allowance.** (a) Notwithstanding any law to the contrary, welfare allowances for clothing and personal needs for individuals receiving medical assistance while residing in any skilled nursing home, intermediate care facility, or medical institution including recipients of Supplemental Security Income, in this state shall not be less than $45 per month from all sources. When benefit amounts for Social Security or Supplemental Security Income recipients are increased pursuant to United States Code, title 42, sections 415(i) and 1382f, the commissioner shall, effective in the month in which the increase takes effect, increase by the same percentage to the nearest whole dollar the clothing and personal needs allowance for individuals receiving medical assistance while residing in any skilled nursing home, medical institution, or intermediate care facility. The commissioner shall provide timely notice to local agencies, providers, and recipients of increases under this provision.

(b) The personal needs allowance may be paid as part of the Minnesota supplemental aid program, and payments to recipients of Minnesota supplemental aid may be made once each three months covering liabilities that accrued during the preceding three months.

(c) The personal needs allowance shall be increased to include income garnished for child support under a court order, up to a maximum of $250 per month but only to the extent that the amount garnished is not deducted as a monthly allowance for children under section 256B.0575, paragraph (a), clause (5).

(d) Solely for the purpose of section 256B.0575, subdivision 1, paragraph (a), clause (1), the personal needs allowance shall be increased to include income garnished for spousal maintenance under a judgment and decree for dissolution of marriage, and any administrative fees garnished for collection efforts.

Subd. 2. **Purpose for allowance.** Neither the skilled nursing home, the intermediate care facility, the medical institution, nor the Department of Human Services shall withhold or deduct any amount of this allowance for any purpose contrary to this section.

Subd. 3. **Prohibition on commingling of funds.** The nursing home may not commingle the patient's funds with nursing home funds or in any way use the funds for nursing home purposes.

Subd. 4. **Field audits required.** The commissioner of human services shall conduct field audits at the same time as cost report audits required under section 256B.27, subdivision 2a, and at any other time but at least once every four years, without notice, to determine whether this section was complied with and that the funds provided residents for their personal needs were actually expended for that purpose.

Subd. 5. **Designation on use of funds.** The nursing home may transfer the personal allowance to someone other than the recipient only when the recipient or the recipient's guardian or conservator designates

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that person in writing to receive or expend funds on behalf of the recipient and that person certifies in writing that the allowance is spent for the well-being of the recipient. Persons, other than the recipient, in possession of the personal allowance, may use the allowance only for the well-being of the recipient. Any person, other than the recipient, who, with intent to defraud, uses the personal needs allowance for purposes other than the well-being of the recipient shall be guilty of theft and shall be sentenced pursuant to section 609.52, subdivision 3, clauses (2), (3)(a) and (c), (4), and (5). To prosecute under this subdivision, the attorney general or the appropriate county attorney, acting independently or at the direction of the attorney general, may institute a criminal action. A nursing home that transfers personal needs allowance funds to a person other than the recipient in good faith and in compliance with this section shall not be held liable under this subdivision.

Subd. 6. **Civil action to recover damages.** In addition to the remedies otherwise provided by law, any person injured by a violation of any of the provisions of this section, may bring a civil action and recover damages, together with costs and disbursements, including costs of investigation and reasonable attorney fees, and receive other equitable relief as determined by the court.

History: *1974 c 575 s 15; 1977 c 271 s 1,2; 1980 c 563 s 1; 1982 c 476 s 2; 1984 c 534 s 25; 1984 c 654 art 5 s 58; 1986 c 444; 1987 c 254 s 7; 1987 c 403 art 2 s 86,87; 1988 c 689 art 2 s 153; 1990 c 566 s 7; 1996 c 451 art 2 s 31; 2008 c 277 art 1 s 38; 2014 c 312 art 24 s 38*

256B.36 SPECIAL PERSONAL ALLOWANCE FOR CERTAIN INDIVIDUALS.

In addition to the personal allowance established in section 256B.35, any disabled recipient of medical assistance who is a resident of a nursing facility or intermediate care facility for the developmentally disabled, shall also be permitted a special personal allowance drawn solely from earnings from any employment under an individual plan of rehabilitation. This special personal allowance shall consist of the sum of the following amounts, deducted from earnings in the following order:

(1) $80 for the costs of meals and miscellaneous work expenses;

(2) Federal Insurance Contributions Act payments withheld from the person's earned income;

(3) actual employment related transportation expenses;

(4) other actual employment related expenses; and

(5) state and federal income taxes withheld from the person's earned income, if the person cannot be claimed as exempt from federal income tax withholding.

The maximum special personal allowance from earnings is the sum of clauses (1) to (5).

History: *1974 c 575 s 16; 1985 c 21 s 56; 1986 c 444; 1992 c 513 art 7 s 83; 2005 c 56 s 1*

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

Subdivision 1. **Subrogation.** Upon furnishing medical assistance or alternative care services under section 256B.0913 to any person who has private accident or health care coverage, or receives or has a right to receive health or medical care from any type of organization or entity, or has a cause of action arising out of an occurrence that necessitated the payment of medical assistance, the state agency or the state agency's agent shall be subrogated, to the extent of the cost of medical care furnished, to any rights the person may

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have under the terms of the coverage, or against the organization or entity providing or liable to provide health or medical care, or under the cause of action.

The right of subrogation created in this section includes all portions of the cause of action, notwithstanding any settlement allocation or apportionment that purports to dispose of portions of the cause of action not subject to subrogation.

[See Note.]

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 (c), 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.

Subd. 3. **Notice.** The state agency must be given notice of monetary claims against a person, firm, or corporation that may be liable in damages, or otherwise obligated to pay part or all of the cost of medical care when the state agency has paid or become liable for the cost of care. Notice must be given as follows:

(a) Applicants for medical assistance shall notify the state or local agency of any possible claims when they submit the application. Recipients of medical assistance shall notify the state or local agency of any possible claims when those claims arise.

(b) A person providing medical care services to a recipient of medical assistance shall notify the state agency when the person has reason to believe that a third party may be liable for payment of the cost of medical care.

(c) A person who is party to a claim upon which the state agency may be entitled to subrogation under this section shall notify the state agency of its potential subrogation claim before filing a claim, commencing an action, or negotiating a settlement. A person who is a party to a claim includes the plaintiff, the defendants, and any other party to the cause of action.

Notice given to the local agency is not sufficient to meet the requirements of paragraphs (b) and (c).

Subd. 4. **Recovery.** Upon any judgment, award, or settlement of a cause of action, or any part of it, upon which the state agency has a subrogation right, including compensation for liquidated, unliquidated, or other damages, reasonable costs of collection, including attorney fees, must be deducted first. The full amount of medical assistance paid to or on behalf of the person as a result of the injury must be deducted next and paid to the state agency. The rest must be paid to the medical assistance recipient or other plaintiff. The plaintiff, however, must receive at least one-third of the net recovery after attorney fees and collection costs.

Subd. 5. **Private benefits to be used first.** Private accident and health care coverage including Medicare for medical services is primary coverage and must be exhausted before medical assistance or alternative care services are paid for medical services including home health care, personal care assistance services, hospice, supplies and equipment, or services covered under a Centers for Medicare and Medicaid Services waiver. When a person who is otherwise eligible for medical assistance has private accident or health care

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coverage, including Medicare or a prepaid health plan, the private health care benefits available to the person must be used first and to the fullest extent.

Subd. 5a. **Supplemental payment by medical assistance.** Medical assistance payment will not be made when either covered charges are paid in full by a third party or the provider has an agreement to accept payment for less than charges as payment in full. Payment for patients that are simultaneously covered by medical assistance and a liable third party other than Medicare will be determined as the lesser of clauses (1) to (3):

(1) the patient liability according to the provider/insurer agreement;

(2) covered charges minus the third-party payment amount; or

(3) the medical assistance rate minus the third-party payment amount.

A negative difference will not be implemented.

All providers must reduce their submitted charge to medical assistance programs to reflect all discount amounts applied to the charge by any provider/insurer agreement or contract. The net submitted charge may not be greater than the patient liability for the service.

Subd. 6. **Parent's or obligee's health plan.** When a parent or a person with an obligation of support has enrolled in a prepaid health care plan under section 518A.41, subdivision 1, the commissioner of human services shall limit the recipient of medical assistance to the benefits payable under that prepaid health care plan to the extent that services available under medical assistance are also available under the prepaid health care plan.

History: *1975 c 247 s 7; 1987 c 370 art 2 s 9-14; 1987 c 403 art 3 s 26; 1Sp1993 c 1 art 5 s 87-89; 1996 c 451 art 2 s 32; 1997 c 217 art 2 s 8; 1999 c 245 art 4 s 66,68; 2002 c 277 s 24,32; 2004 c 228 art 1 s 75; 2005 c 164 s 29; 1Sp2005 c 7 s 28; 2006 c 280 s 46; 2009 c 79 art 8 s 56,57*

NOTE: Subdivision 1 was preempted by federal law to the extent that it allows the state to assert a subrogation right against causes of action or settlements for other than medical expenses. Martin ex rel. Hoff v. City of Rochester, 642 N.W.2d 1 (Minn. 2002).

256B.39 AVOIDANCE OF DUPLICATE PAYMENTS.

Billing statements forwarded to recipients of medical assistance by vendors seeking payment for medical care rendered shall clearly state that reimbursement from the state agency is contemplated.

History: *1975 c 247 s 8*

256B.40 SUBSIDY FOR ABORTIONS PROHIBITED.

No medical assistance funds of this state or any agency, county, municipality or any other subdivision thereof and no federal funds passing through the state treasury or the state agency shall be authorized or paid pursuant to this chapter to any person or entity for or in connection with any abortion that is not eligible for funding pursuant to sections 256B.02, subdivision 8, and 256B.0625.

History: *1978 c 508 s 3; 1988 c 689 art 2 s 268*

NOTE: This section was found unconstitutional with regard to public funding for medical services related to therapeutic abortions. Women of State of Minn. by Doe v. Gomez, 542 N.W.2d 17 (Minn. 1995).

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NURSING FACILITY RATES

256B.41 INTENT.

Subdivision 1. **Authority.** The commissioner shall establish, by rule, procedures for determining rates for care of residents of nursing facilities which qualify as vendors of medical assistance, and for implementing the provisions of this section and sections 256B.421, 256B.431, 256B.432, 256B.433, 256B.47, 256B.48, 256B.50, and 256B.502. The procedures shall specify the costs that are allowable for establishing payment rates through medical assistance.

Subd. 2. **Federal requirements.** If any provision of this section and sections 256B.421, 256B.431, 256B.432, 256B.433, 256B.47, 256B.48, 256B.50, and 256B.502, is determined by the United States government to be in conflict with existing or future requirements of the United States government with respect to federal participation in medical assistance, the federal requirements shall prevail.

Subd. 3. **Payment rates.** Payment rates paid to any nursing facility receiving medical assistance payments must be those rates established pursuant to this chapter and rules adopted under it.

History: *1976 c 282 s 1; 1983 c 199 s 10; 1Sp1985 c 9 art 2 s 47; 1992 c 513 art 7 s 84,85,136; 1998 c 407 art 4 s 41*

256B.411 COMPLIANCE WITH STATE STATUTES.

Subdivision 1. **Funding.** Subject to exceptions in section 256B.25, subdivision 3, no nursing facility may receive any state or local payment for providing care to a person eligible for medical assistance, except under the medical assistance program.

Subd. 2. **Requirements.** No medical assistance payments shall be made to any nursing facility unless the nursing facility is certified to participate in the medical assistance program under title XIX of the federal Social Security Act and has in effect a provider agreement with the commissioner meeting the requirements of state and federal statutes and rules. No medical assistance payments shall be made to any nursing facility unless the nursing facility complies with all requirements of Minnesota Statutes including, but not limited to, this chapter and rules adopted under it that govern participation in the program. This section applies whether the nursing facility participates fully in the medical assistance program or is withdrawing from the medical assistance program. No future payments may be made to any nursing facility which has withdrawn or is withdrawing from the medical assistance program except as provided in section 256B.48, subdivision 1a, or federal law. Payments may also be made under a court order entered on or before June 7, 1985, unless the court order is reversed on appeal.

History: *1Sp1985 c 9 art 2 s 48; 1992 c 513 art 7 s 136; 2000 c 449 s 2*

256B.42 [Repealed, 1983 c 199 s 19]

256B.421 DEFINITIONS.

Subdivision 1. **Scope.** For the purposes of this section and sections 256B.41, 256B.411, 256B.431, 256B.432, 256B.433, 256B.434, 256B.47, 256B.48, 256B.50, and 256B.502, the following terms and phrases shall have the meaning given to them.

Subd. 2. **Actual allowable historical operating cost per diem.** "Actual allowable historical operating cost per diem" means the per diem operating costs allowed by the commissioner for the most recent reporting year.

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Subd. 3. **Commissioner.** "Commissioner" means the commissioner of human services.

Subd. 4. **Final rate.** "Final rate" means the rate established after any adjustment by the commissioner, including but not limited to adjustments resulting from cost report reviews and field audits.

Subd. 5. **General and administrative costs.** "General and administrative costs" means all allowable costs for administering the facility, including but not limited to: salaries of administrators, assistant administrators, accounting personnel, data processing personnel, and all clerical personnel; board of directors fees; business office functions and supplies; travel, except as necessary for training programs for nursing personnel and dietitians required to maintain licensure, certification, or professional standards requirements; telephone and telegraph; advertising; membership dues and subscriptions; postage; insurance, except as included as a fringe benefit under subdivision 14; professional services such as legal, accounting and data processing services; central or home office costs; management fees; management consultants; employee training, for any top management personnel and for other than direct resident care related personnel; and business meetings and seminars.

Subd. 6. **Historical operating costs.** "Historical operating costs" means the allowable operating costs incurred by the facility during the reporting year immediately preceding the rate year for which the payment rate becomes effective, after the commissioner has reviewed those costs and determined them to be allowable costs under the medical assistance program, and after the commissioner has applied appropriate limitations such as the limit on administrative costs.

Subd. 7. **Nursing facility.** "Nursing facility" means a facility licensed under chapter 144A or a boarding care facility licensed under sections 144.50 to 144.56.

Subd. 8. **Operating costs.** "Operating costs" means the day-to-day costs of operating the facility in compliance with licensure and certification standards. Operating cost categories are: nursing, including nurses and nursing assistants training; dietary; laundry and linen; housekeeping; plant operation and maintenance; other care-related services; medical directors; licenses, other than license fees required by the Minnesota Department of Health; permits; general and administration; payroll taxes; real estate taxes, license fees required by the Minnesota Department of Health, and actual special assessments paid; and fringe benefits, including clerical training; and travel necessary for training programs for nursing personnel and dietitians required to maintain licensure, certification, or professional standards requirements.

Subd. 9. **Payment rate.** "Payment rate" means the rate determined under section 256B.431.

Subd. 10. **Private paying resident.** "Private paying resident" means a nursing facility resident who is not a medical assistance recipient and whose payment rate is not established by another third party, including the Veterans Administration or Medicare.

Subd. 11. **Rate year.** "Rate year" means the fiscal year for which a payment rate determined under section 256B.431 is effective, from July 1 to the next June 30.

Subd. 12. **Reporting year.** "Reporting year" means the period from October 1 to September 30, immediately preceding the rate year, for which the nursing facility submits reports required under section 256B.48, subdivision 2.

Subd. 13. **Actual resident day.** "Actual resident day" means a billable, countable day as defined by the commissioner.

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Subd. 14. **Fringe benefits.** "Fringe benefits" means workers' compensation insurance, group health or dental insurance, group life insurance, retirement benefits or plans, except for Public Employee Retirement Act contributions, and uniform allowances.

Subd. 15. **Payroll taxes.** "Payroll taxes" means the employer's share of FICA taxes, governmentally required retirement contributions, and state and federal unemployment insurance taxes.

Subd. 16. **Capital assets.** "Capital assets," for purposes of section 256B.431, subdivisions 13 to 21, means a nursing facility's buildings, attached fixtures, land improvements, leasehold improvements, and all additions to or replacements of those assets used directly for resident care.

History: *1983 c 199 s 11; 1984 c 641 s 14-16; 1984 c 654 art 5 s 58; 1985 c 267 s 2; 1Sp1985 c 3 s 26; 1Sp1985 c 9 art 2 s 49; 1987 c 403 art 2 s 88; 1989 c 282 art 3 s 65; 1992 c 513 art 7 s 86,87,136; 1997 c 203 art 3 s 6; 2004 c 206 s 52*

256B.43 [Repealed, 1983 c 199 s 19]

256B.431 RATE DETERMINATION.

Subdivision 1. **In general.** The commissioner shall determine prospective payment rates for resident care costs. For rates established on or after July 1, 1985, the commissioner shall develop procedures for determining operating cost payment rates that take into account the mix of resident needs, geographic location, and other factors as determined by the commissioner. The commissioner shall consider whether the fact that a facility is attached to a hospital or has an average length of stay of 180 days or less should be taken into account in determining rates. The commissioner shall consider the use of the standard metropolitan statistical areas when developing groups by geographic location. The commissioner shall provide notice to each nursing facility on or before August 15 of the rates effective for the following rate year except that if legislation is pending on August 15 that may affect rates for nursing facilities, the commissioner shall set the rates after the legislation is enacted and provide notice to each facility as soon as possible.

Compensation for top management personnel shall continue to be categorized as a general and administrative cost and is subject to any limits imposed on that cost category.

Subd. 2. [Repealed, 2000 c 449 s 15]

Subd. 2a. [Repealed, 2000 c 449 s 15]

Subd. 2b. **Operating costs after July 1, 1985.** (a) For rate years beginning on or after July 1, 1985, the commissioner shall establish procedures for determining per diem reimbursement for operating costs.

(b) The commissioner shall contract with an econometric firm with recognized expertise in and access to national economic change indices that can be applied to the appropriate cost categories when determining the operating cost payment rate.

(c) The commissioner shall analyze and evaluate each nursing facility's cost report of allowable operating costs incurred by the nursing facility during the reporting year immediately preceding the rate year for which the payment rate becomes effective.

(d) The commissioner shall establish limits on actual allowable historical operating cost per diems based on cost reports of allowable operating costs for the reporting year that begins October 1, 1983, taking into consideration relevant factors including resident needs, geographic location, and size of the nursing facility. In developing the geographic groups for purposes of reimbursement under this section, the com-

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missioner shall ensure that nursing facilities in any county contiguous to the Minneapolis-St. Paul seven-county metropolitan area are included in the same geographic group. The limits established by the commissioner shall not be less, in the aggregate, than the 60th percentile of total actual allowable historical operating cost per diems for each group of nursing facilities established under subdivision 1 based on cost reports of allowable operating costs in the previous reporting year. For rate years beginning on or after July 1, 1989, facilities located in geographic group I as described in Minnesota Rules, part 9549.0052, on January 1, 1989, may choose to have the commissioner apply either the care related limits or the other operating cost limits calculated for facilities located in geographic group II, or both, if either of the limits calculated for the group II facilities is higher. The efficiency incentive for geographic group I nursing facilities must be calculated based on geographic group I limits. The phase-in must be established utilizing the chosen limits. For purposes of these exceptions to the geographic grouping requirements, the definitions in Minnesota Rules, parts 9549.0050 to 9549.0059 (Emergency), and 9549.0010 to 9549.0080, apply. The limits established under this paragraph remain in effect until the commissioner establishes a new base period. Until the new base period is established, the commissioner shall adjust the limits annually using the appropriate economic change indices established in paragraph (e). In determining allowable historical operating cost per diems for purposes of setting limits and nursing facility payment rates, the commissioner shall divide the allowable historical operating costs by the actual number of resident days, except that where a nursing facility is occupied at less than 90 percent of licensed capacity days, the commissioner may establish procedures to adjust the computation of the per diem to an imputed occupancy level at or below 90 percent. The commissioner shall establish efficiency incentives as appropriate. The commissioner may establish efficiency incentives for different operating cost categories. The commissioner shall consider establishing efficiency incentives in care related cost categories. The commissioner may combine one or more operating cost categories and may use different methods for calculating payment rates for each operating cost category or combination of operating cost categories. For the rate year beginning on July 1, 1985, the commissioner shall:

(1) allow nursing facilities that have an average length of stay of 180 days or less in their skilled nursing level of care, 125 percent of the care related limit and 105 percent of the other operating cost limit established by rule; and

(2) exempt nursing facilities licensed on July 1, 1983, by the commissioner to provide residential services for the physically disabled under Minnesota Rules, parts 9570.2000 to 9570.3600, from the care related limits and allow 105 percent of the other operating cost limit established by rule.

For the purpose of calculating the other operating cost efficiency incentive for nursing facilities referred to in clause (1) or (2), the commissioner shall use the other operating cost limit established by rule before application of the 105 percent.

(e) The commissioner shall establish a composite index or indices by determining the appropriate economic change indicators to be applied to specific operating cost categories or combination of operating cost categories.

(f) Each nursing facility shall receive an operating cost payment rate equal to the sum of the nursing facility's operating cost payment rates for each operating cost category. The operating cost payment rate for an operating cost category shall be the lesser of the nursing facility's historical operating cost in the category increased by the appropriate index established in paragraph (e) for the operating cost category plus an efficiency incentive established pursuant to paragraph (d) or the limit for the operating cost category increased by the same index. If a nursing facility's actual historic operating costs are greater than the prospective payment rate for that rate year, there shall be no retroactive cost settle up. In establishing payment rates for

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one or more operating cost categories, the commissioner may establish separate rates for different classes of residents based on their relative care needs.

(g) The commissioner shall include the reported actual real estate tax liability or payments in lieu of real estate tax of each nursing facility as an operating cost of that nursing facility. Allowable costs under this subdivision for payments made by a nonprofit nursing facility that are in lieu of real estate taxes shall not exceed the amount which the nursing facility would have paid to a city or township and county for fire, police, sanitation services, and road maintenance costs had real estate taxes been levied on that property for those purposes. For rate years beginning on or after July 1, 1987, the reported actual real estate tax liability or payments in lieu of real estate tax of nursing facilities shall be adjusted to include an amount equal to one-half of the dollar change in real estate taxes from the prior year. The commissioner shall include a reported actual special assessment, and reported actual license fees required by the Minnesota Department of Health, for each nursing facility as an operating cost of that nursing facility. For rate years beginning on or after July 1, 1989, the commissioner shall include a nursing facility's reported Public Employee Retirement Act contribution for the reporting year as apportioned to the care-related operating cost categories and other operating cost categories multiplied by the appropriate composite index or indices established pursuant to paragraph (e) as costs under this paragraph. Total adjusted real estate tax liability, payments in lieu of real estate tax, actual special assessments paid, the indexed Public Employee Retirement Act contribution, and license fees paid as required by the Minnesota Department of Health, for each nursing facility (1) shall be divided by actual resident days in order to compute the operating cost payment rate for this operating cost category, (2) shall not be used to compute the care-related operating cost limits or other operating cost limits established by the commissioner, and (3) shall not be increased by the composite index or indices established pursuant to paragraph (e), unless otherwise indicated in this paragraph.

(h) For rate years beginning on or after July 1, 1987, the commissioner shall adjust the rates of a nursing facility that meets the criteria for the special dietary needs of its residents and the requirements in section 31.651. The adjustment for raw food cost shall be the difference between the nursing facility's allowable historical raw food cost per diem and 115 percent of the median historical allowable raw food cost per diem of the corresponding geographic group.

The rate adjustment shall be reduced by the applicable phase-in percentage as provided under subdivision 2h.

Subd. 2c. [Repealed, 2012 c 216 art 9 s 38]

Subd. 2d. **Cost report or audit.** If an annual cost report or field audit indicates that expenditures for direct resident care have been reduced in amounts large enough to indicate a possible detrimental effect on the quality of care, the commissioner shall notify the commissioner of health and the interagency long-term care planning committee. If a field audit reveals that unallowable expenditures have been included in the nursing facility's historical operating costs, the commissioner shall disallow the expenditures and recover the entire overpayment. The commissioner shall establish, by rule, procedures for assessing an interest charge at the rate determined for unpaid taxes or penalties under section 270C.40 on any outstanding balance resulting from an overpayment or underpayment.

Subd. 2e. **Contracts for services for ventilator-dependent persons.** (a) The commissioner may negotiate with a nursing facility eligible to receive medical assistance payments to provide services to a ventilator-dependent person identified by the commissioner according to criteria developed by the commissioner, including:

(1) nursing facility care has been recommended for the person by a preadmission screening team;

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(2) the person has been hospitalized and no longer requires inpatient acute care hospital services; and

(3) the commissioner has determined that necessary services for the person cannot be provided under existing nursing facility rates.

The commissioner may negotiate an adjustment to the operating cost payment rate for a nursing facility with a resident who is ventilator-dependent, for that resident. The negotiated adjustment must reflect only the actual additional cost of meeting the specialized care needs of a ventilator-dependent person identified by the commissioner for whom necessary services cannot be provided under existing nursing facility rates and which are not otherwise covered under Minnesota Rules, parts 9549.0010 to 9549.0080 or 9505.0170 to 9505.0475. For persons who are initially admitted to a nursing facility before July 1, 2001, and have their payment rate under this subdivision negotiated after July 1, 2001, the negotiated payment rate must not exceed 200 percent of the highest multiple bedroom payment rate for the facility, as initially established by the commissioner for the rate year for case mix classification K; or, upon implementation of the RUG's-based case mix system, 200 percent of the highest RUG's rate. For persons initially admitted to a nursing facility on or after July 1, 2001, the negotiated payment rate must not exceed 300 percent of the facility's multiple bedroom payment rate for case mix classification K; or, upon implementation of the RUG's-based case mix system, 300 percent of the highest RUG's rate. The negotiated adjustment shall not affect the payment rate charged to private paying residents under the provisions of section 256B.48, subdivision 1.

(b) Effective July 1, 2007, or upon opening a unit of at least ten beds dedicated to care of ventilator-dependent persons in partnership with Mayo Health Systems, whichever is later, the operating payment rates for residents determined eligible under paragraph (a) of a nursing facility in Waseca County that on February 1, 2007, was licensed for 70 beds and reimbursed under this section, section 256B.434, or section 256B.441, shall be 300 percent of the facility's highest RUG rate.

Subd. 2f. [Repealed, 2000 c 449 s 15]

Subd. 2g. [Repealed, 2012 c 216 art 9 s 38]

Subd. 2h. [Repealed, 2000 c 449 s 15]

Subd. 2i. [Repealed, 2012 c 216 art 9 s 38]

Subd. 2j. [Repealed, 2012 c 216 art 9 s 38]

Subd. 2k. [Repealed, 2012 c 216 art 9 s 38]

Subd. 2l. [Repealed, 2012 c 216 art 9 s 38]

Subd. 2m. [Repealed, 2000 c 449 s 15]

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

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Subd. 2o. [Repealed, 2012 c 216 art 9 s 38]

Subd. 2p. [Repealed, 2000 c 449 s 15]

Subd. 2q. [Repealed, 2000 c 449 s 15]

Subd. 2r. **Payment restrictions on leave days.** (a) Effective July 1, 1993, the commissioner shall limit payment for leave days in a nursing facility to 79 percent of that nursing facility's total payment rate for the involved resident.

(b) For services rendered on or after July 1, 2003, for facilities reimbursed under this section or section 256B.434, the commissioner shall limit payment for leave days in a nursing facility to 60 percent of that nursing facility's total payment rate for the involved resident.

(c) For services rendered on or after July 1, 2011, for facilities reimbursed under this chapter, the commissioner shall limit payment for leave days in a nursing facility to 30 percent of that nursing facility's total payment rate for the involved resident, and shall allow this payment only when the occupancy of the nursing facility, inclusive of bed hold days, is equal to or greater than 96 percent, notwithstanding Minnesota Rules, part 9505.0415.

Subd. 2s. **Nonallowable cost.** Costs incurred for any activities which are directed at or are intended to influence or dissuade employees in the exercise of their legal rights to freely engage in the process of selecting an exclusive representative for the purpose of collective bargaining with their employer shall not be allowable for purposes of setting payment rates.

Subd. 2t. **Payment limitation.** For services rendered on or after July 1, 2003, for facilities reimbursed under this chapter, the Medicaid program shall only pay a co-payment during a Medicare-covered skilled nursing facility stay if the Medicare rate less the resident's co-payment responsibility is less than the Medicaid RUG-III case-mix payment rate, or, beginning January 1, 2012, the Medicaid RUG-IV case-mix payment rate. The amount that shall be paid by the Medicaid program is equal to the amount by which the Medicaid RUG-III or RUG-IV case-mix payment rate exceeds the Medicare rate less the co-payment responsibility. Health plans paying for nursing home services under section 256B.69, subdivision 6a, may limit payments as allowed under this subdivision.

Subd. 3. [Repealed, 2000 c 449 s 15]

Subd. 3a. **Property-related costs after July 1, 1985.** (a) For rate years beginning on or after July 1, 1985, the commissioner, by permanent rule, shall reimburse nursing facility providers that are vendors in the medical assistance program for the rental use of real estate and depreciable equipment. "Real estate" means land improvements, buildings, and attached fixtures used directly for resident care. "Depreciable equipment" means the standard movable resident care equipment and support service equipment generally used in long-term care facilities.

(b) In developing the method for determining payment rates for the rental use of nursing facilities, the commissioner shall consider factors designed to:

(1) simplify the administrative procedures for determining payment rates for property-related costs;

(2) minimize discretionary or appealable decisions;

(3) eliminate any incentives to sell nursing facilities;

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(4) recognize legitimate costs of preserving and replacing property;

(5) recognize the existing costs of outstanding indebtedness allowable under the statutes and rules in effect on May 1, 1983;

(6) address the current value of, if used directly for patient care, land improvements, buildings, attached fixtures, and equipment;

(7) establish an investment per bed limitation;

(8) reward efficient management of capital assets;

(9) provide equitable treatment of facilities;

(10) consider a variable rate; and

(11) phase-in implementation of the rental reimbursement method.

(c) For rate years beginning on or after July 1, 1987, a nursing facility which has reduced licensed bed capacity after January 1, 1986, shall be allowed to:

(1) aggregate the applicable investment per bed limits based on the number of beds licensed prior to the reduction; and

(2) establish capacity days for each rate year following the licensure reduction based on the number of beds licensed on the previous April 1 if the commissioner is notified of the change by April 4. The notification must include a copy of the delicensure request that has been submitted to the commissioner of health.

(d) For rate years beginning on or after July 1, 1989, the interest expense that results from a refinancing of a nursing facility's demand call loan, when the loan that must be refinanced was incurred before May 22, 1983, is an allowable interest expense if:

(1) the demand call loan or any part of it was in the form of a loan that was callable at the demand of the lender;

(2) the demand call loan or any part of it was called by the lender through no fault of the nursing facility;

(3) the demand call loan or any part of it was made by a government agency operating under a statutory or regulatory loan program;

(4) the refinanced debt does not exceed the sum of the allowable remaining balance of the demand call loan at the time of payment on the demand call loan and refinancing costs;

(5) the term of the refinanced debt does not exceed the remaining term of the demand call loan, had the debt not been subject to an on-call payment demand; and

(6) the refinanced debt is not a debt between related organizations as defined in Minnesota Rules, part 9549.0020, subpart 38.

Subd. 3b. [Repealed, 2000 c 449 s 15]

Subd. 3c. [Repealed, 2012 c 216 art 9 s 38]

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Subd. 3d. [Repealed, 2000 c 449 s 15]

Subd. 3e. **Hospital-attached convalescent and nursing care facilities.** If a nonprofit or community-operated hospital and attached convalescent and nursing care facility suspend operation of the hospital, the surviving nursing care facility must be allowed to continue its status as a hospital-attached convalescent and nursing care facility for reimbursement purposes in five subsequent rate years. In the fourth year the facility shall receive 60 percent of the difference between the hospital-attached limit and the freestanding nursing facility limit, and in the fifth year the facility shall receive 30 percent of the difference.

Subd. 3f. **Property costs after July 1, 1988.** (a) For the rate year beginning July 1, 1988, the replacement-cost-new per bed limit must be $32,571 per licensed bed in multiple bedrooms and $48,857 per licensed bed in a single bedroom. For the rate year beginning July 1, 1989, the replacement-cost-new per bed limit for a single bedroom must be $49,907 adjusted according to Minnesota Rules, part 9549.0060, subpart 4, item A, subitem (1). Beginning January 1, 1990, the replacement-cost-new per bed limits must be adjusted annually as specified in Minnesota Rules, part 9549.0060, subpart 4, item A, subitem (1). Beginning January 1, 1991, the replacement-cost-new per bed limits will be adjusted annually as specified in Minnesota Rules, part 9549.0060, subpart 4, item A, subitem (1), except that the index utilized will be the Bureau of Economic Analysis: Price Indexes for Private Fixed Investments in Structures; Special Care.

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

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

(d) For rate years beginning on July 1, 1988, and July 1, 1989, the commissioner shall add ten cents per resident per day to each nursing facility's property-related payment rate. The ten-cent property-related payment rate increase is not cumulative from rate year to rate year. For the rate year beginning July 1, 1990, the commissioner shall increase each nursing facility's equipment allowance as established in Minnesota Rules, part 9549.0060, subpart 10, by ten cents per resident per day. For rate years beginning on or after July 1, 1991, the adjusted equipment allowance must be adjusted annually for inflation as in Minnesota Rules, part 9549.0060, subpart 10, item E. For the rate period beginning October 1, 1992, the equipment allowance for each nursing facility shall be increased by 28 percent. For rate years beginning after June 30, 1993, the allowance must be adjusted annually for inflation.

(e) For rate years beginning on or after July 1, 1990, Minnesota Rules, part 9549.0060, subpart 5, item E, shall not apply to outstanding related organization debt incurred prior to May 23, 1983, provided that the debt was an allowable debt under Minnesota Rules, parts 9510.0010 to 9510.0480, the debt is subject to repayment through annual principal payments, and the nursing facility demonstrates to the commissioner's satisfaction that the interest rate on the debt was less than market interest rates for similar arm's-length transactions at the time the debt was incurred. If the debt was incurred due to a sale between family

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members, the nursing facility must also demonstrate that the seller no longer participates in the management or operation of the nursing facility. Debts meeting the conditions of this paragraph are subject to all other provisions of Minnesota Rules, parts 9549.0010 to 9549.0080.

(f) For rate years beginning on or after July 1, 1990, a nursing facility with operating lease costs incurred for the nursing facility's buildings shall receive its building capital allowance computed in accordance with Minnesota Rules, part 9549.0060, subpart 8. If an operating lease provides that the lessee's rent is adjusted to recognize improvements made by the lessor and related debt, the costs for capital improvements and related debt shall be allowed in the computation of the lessee's building capital allowance, provided that reimbursement for these costs under an operating lease shall not exceed the rate otherwise paid.

Subd. 3g. **Property costs after July 1, 1990, for certain facilities.** (a) For rate years beginning on or after July 1, 1990, nursing facilities that, on or after January 1, 1976, but prior to January 1, 1987, were newly licensed after new construction, or increased their licensed beds by a minimum of 35 percent through new construction, and whose building capital allowance is less than their allowable annual principal and interest on allowable debt prior to the application of the replacement-cost-new per bed limit and whose remaining weighted average debt amortization schedule as of January 1, 1988, exceeded 15 years, must receive a property-related payment rate equal to the greater of their rental per diem or their annual allowable principal and allowable interest without application of the replacement-cost-new per bed limit, divided by their capacity days as determined under Minnesota Rules, part 9549.0060, subpart 11, as modified by subdivision 3f, paragraph (c), for the preceding reporting year, plus their equipment allowance. A nursing facility that is eligible for a property-related payment rate under this subdivision and whose property-related payment rate in a subsequent rate year is its rental per diem must continue to have its property-related payment rates established for all future rate years based on the rental reimbursement method in Minnesota Rules, part 9549.0060.

The commissioner may require the nursing facility to apply for refinancing as a condition of receiving special rate treatment under this subdivision.

(b) If a nursing facility is eligible for a property-related payment rate under this subdivision, and the nursing facility's debt is refinanced after October 1, 1988, the provisions in paragraphs (1) to (7) also apply to the property-related payment rate for rate years beginning on or after July 1, 1990.

(1) A nursing facility's refinancing must not include debts with balloon payments.

(2) If the issuance costs, including issuance costs on the debt refinanced, are financed as part of the refinancing, the historical cost of capital assets limit in Minnesota Rules, part 9549.0060, subpart 5, item A, subitem (6), includes issuance costs that do not exceed seven percent of the debt refinanced, plus the related issuance costs. For purposes of this paragraph, issuance costs means the fees charged by the underwriter, issuer, attorneys, bond raters, appraisers, and trustees, and includes the cost of printing, title insurance, registration tax, and a feasibility study for the refinancing of a nursing facility's debt. Issuance costs do not include bond premiums or discounts when bonds are sold at other than their par value, points, or a bond reserve fund. To the extent otherwise allowed under this paragraph, the straight-line amortization of the refinancing issuance costs is not an allowable cost.

(3) The annual principal and interest expense payments and any required annual municipal fees on the nursing facility's refinancing replace those of the refinanced debt and, together with annual principal and interest payments on other allowable debts, are allowable costs subject to the limitation on historical cost of capital assets plus issuance costs as limited in paragraph (2), if any.

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(4) If the nursing facility's refinancing includes zero coupon bonds, the commissioner shall establish a monthly debt service payment schedule based on an annuity that will produce an amount equal to the zero coupon bonds at maturity. The term and interest rate is the term and interest rate of the zero coupon bonds. Any refinancing to repay the zero coupon bonds is not an allowable cost.

(5) The annual amount of annuity payments is added to the nursing facility's allowable annual principal and interest payment computed in paragraph (3).

(6) The property-related payment rate is equal to the amount in paragraph (5), divided by the nursing facility's capacity days as determined under Minnesota Rules, part 9549.0060, subpart 11, as modified by subdivision 3f, paragraph (c), for the preceding reporting year plus an equipment allowance.

(7) Except as provided in this subdivision, the provisions of Minnesota Rules, part 9549.0060 apply.

Subd. 3h. [Repealed, 2000 c 449 s 15]

Subd. 3i. **Property costs for the rate year beginning July 1, 1990.** Notwithstanding Minnesota Rules, part 9549.0060, subpart 13, item H, the commissioner shall determine property-related payment rates for nursing facilities for the rate year beginning July 1, 1990, as follows:

(a) The property-related payment rate for a nursing facility that qualifies under subdivision 3g is the greater of the rate determined under that subdivision or the rate determined under paragraph (c), (d), or (e), whichever is applicable.

(b) Nursing facilities shall be grouped according to the type of property-related payment rate the commissioner determined for the rate year beginning July 1, 1989. A nursing facility whose property-related payment rate was determined under Minnesota Rules, part 9549.0060, subpart 13, item A (full rental reimbursement), shall be considered group A. A nursing facility whose property-related payment rate was determined under Minnesota Rules, part 9549.0060, subpart 13, item B (phase-down to full rental reimbursement), shall be considered group B. A nursing facility whose property-related payment rate was determined under Minnesota Rules, part 9549.0060, subpart 13, item C or D (phase-up to full rental reimbursement), shall be considered group C.

(c) For the rate year beginning July 1, 1990, a group A nursing facility shall receive its property-related payment rate determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section.

(d) For the rate year beginning July 1, 1990, a Group B nursing facility shall receive the greater of 87 percent of the property-related payment rate in effect on July 1, 1989; or the rental per diem rate determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section in effect on July 1, 1990; or the sum of 100 percent of the nursing facility's allowable principal and interest expense, plus its equipment allowance multiplied by the resident days for the reporting year ending September 30, 1989, divided by the nursing facility's capacity days as determined under Minnesota Rules, part 9549.0060, subpart 11, as modified by subdivision 3f, paragraph (c); except that the nursing facility's property-related payment rate must not exceed its property-related payment rate in effect on July 1, 1989.

(e) For the rate year beginning July 1, 1990, a group C nursing facility shall receive its property-related payment rate determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section, except the rate must not exceed the lesser of its property-related payment rate determined for the rate year beginning July 1, 1989, multiplied by 116 percent or its rental per diem rate determined effective July 1, 1990.

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(f) The property-related payment rate for a nursing facility that qualifies for a rate adjustment under Minnesota Rules, part 9549.0060, subpart 13, item G (special reappraisals), shall have the property-related payment rate determined in paragraphs (a) to (e) adjusted according to the provisions in that rule.

(g) Except as provided in subdivision 4, paragraph (f), and subdivision 11, a nursing facility that has a change in ownership or a reorganization of provider entity is subject to the provisions of Minnesota Rules, part 9549.0060, subpart 13, item F.

Subd. 3j. [Repealed, 2000 c 449 s 15]

Subd. 4. [Repealed, 2000 c 449 s 15]

Subd. 5. [Repealed, 2000 c 449 s 15]

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

Subd. 7. [Repealed, 2000 c 449 s 15]

Subd. 8. [Repealed, 2000 c 449 s 15]

Subd. 9. [Repealed, 2000 c 449 s 15]

Subd. 9a. [Repealed, 2000 c 449 s 15]

Subd. 10. **Property rate adjustments and construction projects.** A nursing facility completing a construction project that is eligible for a rate adjustment under section 256B.434, subdivision 4f, and that was not approved through the moratorium exception process in section 144A.073 must request from the commissioner a property-related payment rate adjustment. If the request is made within 60 days after the construction project's completion date, the effective date of the rate adjustment is the first of the month following the completion date. If the request is made more than 60 days after the completion date, the rate adjustment is effective on the first of the month following the request. The commissioner shall provide a rate notice reflecting the allowable costs within 60 days after receiving all the necessary information to compute the rate adjustment. No sooner than the effective date of the rate adjustment for the construction project, a nursing facility may adjust its rates by the amount anticipated to be allowed. Any amounts collected from private pay residents in excess of the allowable rate must be repaid to private pay residents with interest at the rate used by the commissioner of revenue for the late payment of taxes and in effect on the date the rate increase is effective. Construction projects with completion dates within one year of the completion date associated with the property rate adjustment request and phased projects with project completion dates within three years of the last phase of the phased project must be aggregated for purposes of the minimum thresholds in subdivisions 16 and 17, and the maximum threshold in section 144A.071, subdivision 2. "Construction project" and "project construction costs" have the meanings given them in Minnesota Statutes, section 144A.071, subdivision 1a.

Subd. 11. [Repealed, 2012 c 216 art 9 s 38]

Subd. 12. [Repealed, 2000 c 449 s 15]

Subd. 13. **Hold-harmless property-related rates.** (a) Terms used in subdivisions 13 to 21 shall be as defined in Minnesota Rules, parts 9549.0010 to 9549.0080, and this section.

(b) Except as provided in this subdivision, for rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, the property-related rate for a nursing facility shall be the greater of $4

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or the property-related payment rate in effect on September 30, 1992. In addition, the incremental increase in the nursing facility's rental rate will be determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section.

(c) Notwithstanding Minnesota Rules, part 9549.0060, subpart 13, item F, a nursing facility that has a sale permitted under subdivision 14 after June 30, 1992, shall receive the property-related payment rate in effect at the time of the sale or reorganization. For rate periods beginning after October 1, 1992, and for rate years beginning after June 30, 1993, a nursing facility shall receive, in addition to its property-related payment rate in effect at the time of the sale, the incremental increase allowed under subdivision 14.

(d) For rate years beginning after June 30, 1993, the property-related rate for a nursing facility licensed after July 1, 1989, after relocating its beds from a separate nursing home to a building formerly used as a hospital and sold during the cost reporting year ending September 30, 1991, shall be its property-related rate prior to the sale in addition to the incremental increases provided under this section effective on October 1, 1992, of 29 cents per day, and any incremental increases after October 1, 1992, calculated by using its rental rate under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section, recognizing the current appraised value of the facility at the new location, and including as allowable debt otherwise allowable debt incurred to remodel the facility in the new location prior to the relocation of beds.

Subd. 14. [Repealed, 2012 c 216 art 9 s 38]

Subd. 15. **Capital repair and replacement cost reporting and rate calculation.** For rate years beginning after June 30, 1993, a nursing facility's capital repair and replacement payment rate shall be established annually as provided in paragraphs (a) to (e).

(a) Notwithstanding Minnesota Rules, part 9549.0060, subpart 12, the costs of any of the following items not included in the equity incentive computations under subdivision 16 or reported as a capital asset addition under subdivision 18, paragraph (b), including cash payment for equity investment and principal and interest expense for debt financing, must be reported in the capital repair and replacement cost category:

(1) wall coverings;

(2) paint;

(3) floor coverings;

(4) window coverings;

(5) roof repair; and

(6) window repair or replacement.

(b) Notwithstanding Minnesota Rules, part 9549.0060, subpart 12, the repair or replacement of a capital asset not included in the equity incentive computations under subdivision 16 or reported as a capital asset addition under subdivision 18, paragraph (b), must be reported under this subdivision when the cost of the item exceeds $500, or in the plant operations and maintenance cost category when the cost of the item is equal to or less than $500.

(c) To compute the capital repair and replacement payment rate, the allowable annual repair and replacement costs for the reporting year must be divided by actual resident days for the reporting year. The

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annual allowable capital repair and replacement costs shall not exceed $150 per licensed bed. The excess of the allowed capital repair and replacement costs over the capital repair and replacement limit shall be a cost carryover to succeeding cost reporting periods, except that sale of a facility, under subdivision 14, shall terminate the carryover of all costs except those incurred in the most recent cost reporting year. The termination of the carryover shall have effect on the capital repair and replacement rate on the same date as provided in subdivision 14, paragraph (f), for the sale. For rate years beginning after June 30, 1994, the capital repair and replacement limit shall be subject to the index provided in subdivision 3f, paragraph (a). For purposes of this subdivision, the number of licensed beds shall be the number used to calculate the nursing facility's capacity days. The capital repair and replacement rate must be added to the nursing facility's total payment rate.

(d) Capital repair and replacement costs under this subdivision shall not be counted as either care-related or other operating costs, nor subject to care-related or other operating limits.

(e) If costs otherwise allowable under this subdivision are incurred as the result of a project approved under the moratorium exception process in section 144A.073, or in connection with an addition to or replacement of buildings, attached fixtures, or land improvements for which the total historical cost of these assets exceeds the lesser of $150,000 or ten percent of the nursing facility's appraised value, these costs must be claimed under subdivision 16 or 17, as appropriate.

Subd. 16. **Major additions and replacements; equity incentive.** For rate years beginning after June 30, 1993, if a nursing facility acquires capital assets in connection with a project approved under the moratorium exception process in section 144A.073 or in connection with an addition to or replacement of buildings, attached fixtures, or land improvements for which the total historical cost of those capital asset additions exceeds the lesser of $150,000 or ten percent of the most recent appraised value, the nursing facility shall be eligible for an equity incentive payment rate as in paragraphs (a) to (d). This computation is separate from the determination of the nursing facility's rental rate. An equity incentive payment rate as computed under this subdivision is limited to one in a 12-month period.

(a) An eligible nursing facility shall receive an equity incentive payment rate equal to the allowable historical cost of the capital asset acquired, minus the allowable debt directly identified to that capital asset, multiplied by the equity incentive factor as described in paragraphs (b) and (c), and divided by the nursing facility's occupancy factor under subdivision 3f, paragraph (c). This amount shall be added to the nursing facility's total payment rate and shall be effective the same day as the incremental increase in paragraph (d) or subdivision 17. The allowable historical cost of the capital assets and the allowable debt shall be determined as provided in Minnesota Rules, parts 9549.0010 to 9549.0080, and this section.

(b) The equity incentive factor shall be determined under clauses (1) to (4):

(1) divide the initial allowable debt in paragraph (a) by the initial historical cost of the capital asset additions referred to in paragraph (a), then cube the quotient,

(2) subtract the amount calculated in clause (1) from the number one,

(3) determine the difference between the rental factor and the lesser of two percentage points above the posted yield for standard conventional fixed rate mortgages of the Federal Home Loan Mortgage Corporation as published in the Wall Street Journal and in effect on the first day of the month the debt or cost is incurred, or 16 percent,

(4) multiply the amount calculated in clause (2) by the amount calculated in clause (3).

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(c) The equity incentive payment rate shall be limited to the term of the allowable debt in paragraph (a), not greater than 20 years nor less than ten years. If no debt is incurred in acquiring the capital asset, the equity incentive payment rate shall be paid for ten years. The sale of a nursing facility under subdivision 14 shall terminate application of the equity incentive payment rate effective on the date provided in subdivision 14, paragraph (f), for the sale.

(d) A nursing facility with an addition to or a renovation of its buildings, attached fixtures, or land improvements meeting the criteria in this subdivision and not receiving the property-related payment rate adjustment in subdivision 17, shall receive the incremental increase in the nursing facility's rental rate as determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section. The incremental increase shall be added to the nursing facility's property-related payment rate. The effective date of this incremental increase shall be the first day of the month following the month in which the addition or replacement is completed.

Subd. 17. **Special provisions for moratorium exceptions.** 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; (3) has completed a construction project approved under section 144A.071, subdivision 4c; or (4) 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 subdivisions 17 to 17f.

Subd. 17a. **Allowable interest expense.** (a) 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 ten 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.

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

Subd. 17b. [Repealed, 2012 c 216 art 9 s 38]

Subd. 17c. **Replacement-costs-new per bed limit.** 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 re-

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placement 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.

Subd. 17d. **Determination of rental per diem for total replacement projects.** (a) For purposes of this subdivision, a total replacement means the complete replacement of the nursing facility's physical plant through the construction of a new physical plant, the transfer of the nursing facility's license from one physical plant location to another, or a new building addition to relocate beds from three- and four-bed wards. For total replacement projects completed on or after July 1, 1992, the commissioner shall compute the incremental change in the nursing facility's rental per diem, for rate years beginning on or after July 1, 1995, by replacing its appraised value, including the historical capital asset costs, and the capital debt and interest costs with the new nursing facility's allowable capital asset costs and the related allowable capital debt and interest costs. If the new nursing facility has decreased its licensed capacity, the aggregate investment per bed limit in subdivision 3a, paragraph (c), shall apply.

(b) 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 subdivision, 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).

(c) In the case of either type of total replacement as authorized under section 144A.071 or 144A.073, the provisions of subdivisions 17 to 17f shall also apply.

(d) 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.

Subd. 17e. **Replacement-costs-new per bed limit effective October 1, 2007.** Notwithstanding Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), for a total replacement, as defined in subdivision 17d, authorized under section 144A.071 or 144A.073 after July 1, 1999, any building project that is a relocation, renovation, upgrading, or conversion completed on or after July 1, 2001, or any building project eligible for reimbursement under section 256B.434, subdivision 4f, 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

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adjusted annually as specified in subdivision 3f, paragraph (a), beginning January 1, 2000. These amounts must be increased annually as specified in subdivision 3f, paragraph (a), beginning October 1, 2012.

Subd. 17f. [Repealed, 2012 c 216 art 9 s 38]

Subd. 18. **Updating appraisals, additions, and replacements.** (a) Notwithstanding Minnesota Rules, part 9549.0060, subparts 1 to 3, the appraised value, routine updating of the appraised value, and special reappraisals are subject to this subdivision.

For all rate years after June 30, 1993, the commissioner shall no longer conduct any appraisals under Minnesota Rules, part 9549.0060, for the purpose of determining property-related payment rates.

(b) Notwithstanding Minnesota Rules, part 9549.0060, subpart 2, for rate years beginning after June 30, 1993, the commissioner shall routinely update the appraised value of each nursing facility by adding the cost of capital asset acquisitions to its allowable appraised value.

The commissioner shall also annually index each nursing facility's allowable appraised value by the inflation index referenced in subdivision 3f, paragraph (a), for the purpose of computing the nursing facility's annual rental rate. In annually adjusting the nursing facility's appraised value, the commissioner must not include the historical cost of capital assets acquired during the reporting year in the nursing facility's appraised value.

In addition, the nursing facility's appraised value must be reduced by the historical cost of capital asset disposals or applicable credits such as public grants and insurance proceeds. Capital asset additions and disposals must be reported on the nursing facility's annual cost report in the reporting year of acquisition or disposal. The incremental increase in the nursing facility's rental rate resulting from this annual adjustment as determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section shall be added to the nursing facility's property-related payment rate for the rate year following the reporting year.

Subd. 19. [Repealed, 2012 c 216 art 9 s 38]

Subd. 20. [Repealed, 2012 c 216 art 9 s 38]

Subd. 21. **Indexing thresholds.** Beginning January 1, 1993, and each January 1 thereafter, the commissioner shall annually update the dollar thresholds in subdivisions 15, paragraph (e), 16, and 17, and in section 144A.071, subdivisions 2 and 4a, clauses (b) and (e), by the inflation index referenced in subdivision 3f, paragraph (a).

Subd. 22. **Changes to nursing facility reimbursement.** The nursing facility reimbursement changes in paragraphs (a) to (d) apply to Minnesota Rules, parts 9549.0010 to 9549.0080, and this section, and are effective for rate years beginning on or after July 1, 1993, unless otherwise indicated.

(a) In addition to the approved pension or profit-sharing plans allowed by the reimbursement rule, the commissioner shall allow those plans specified in Internal Revenue Code, sections 403(b) and 408(k).

(b) The commissioner shall allow as workers' compensation insurance costs under section 256B.421, subdivision 14, the costs of workers' compensation coverage obtained under the following conditions:

(1) a plan approved by the commissioner of commerce as a Minnesota group or individual self-insurance plan as provided in section 79A.03;

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(2) a plan in which:

(i) the nursing facility, directly or indirectly, purchases workers' compensation coverage in compliance with section 176.181, subdivision 2, from an authorized insurance carrier;

(ii) a related organization to the nursing facility reinsures the workers' compensation coverage purchased, directly or indirectly, by the nursing facility; and

(iii) all of the conditions in clause (4) are met;

(3) a plan in which:

(i) the nursing facility, directly or indirectly, purchases workers' compensation coverage in compliance with section 176.181, subdivision 2, from an authorized insurance carrier;

(ii) the insurance premium is calculated retrospectively, including a maximum premium limit, and paid using the paid loss retro method; and

(iii) all of the conditions in clause (4) are met;

(4) additional conditions are:

(i) the costs of the plan are allowable under the federal Medicare program;

(ii) the reserves for the plan are maintained in an account controlled and administered by a person which is not a related organization to the nursing facility;

(iii) the reserves for the plan cannot be used, directly or indirectly, as collateral for debts incurred or other obligations of the nursing facility or related organizations to the nursing facility;

(iv) if the plan provides workers' compensation coverage for non-Minnesota nursing facilities, the plan's cost methodology must be consistent among all nursing facilities covered by the plan, and if reasonable, is allowed notwithstanding any reimbursement laws regarding cost allocation to the contrary;

(v) central, affiliated, corporate, or nursing facility costs related to their administration of the plan are costs which must remain in the nursing facility's administrative cost category and must not be allocated to other cost categories;

(vi) required security deposits, whether in the form of cash, investments, securities, assets, letters of credit, or in any other form are not allowable costs for purposes of establishing the facilities payment rate; and

(vii) for the rate year beginning on July 1, 1998, a group of nursing facilities related by common ownership that self-insures workers' compensation may allocate its directly identified costs of self-insuring its Minnesota nursing facility workers among those nursing facilities in the group that are reimbursed under this section or section 256B.434. The method of cost allocation shall be based on the ratio of each nursing facility's total allowable salaries and wages to that of the nursing facility group's total allowable salaries and wages, then similarly allocated within each nursing facility's operating cost categories. The costs associated with the administration of the group's self-insurance plan must remain classified in the nursing facility's administrative cost category. A written request of the nursing facility group's election to use this alternate

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method of allocation of self-insurance costs must be received by the commissioner no later than May 1, 1998, to take effect July 1, 1998, or such costs shall continue to be allocated under the existing cost allocation methods. Once a nursing facility group elects this method of cost allocation for its workers' compensation self-insurance costs, it shall remain in effect until such time as the group no longer self-insures these costs;

(5) any costs allowed pursuant to clauses (1) to (3) are subject to the following requirements:

(i) if the nursing facility is sold or otherwise ceases operations, the plan's reserves must be subject to an actuarially based settle up after 36 months from the date of sale or the date on which operations ceased. The facility's medical assistance portion of the total excess plan reserves must be paid to the state within 30 days following the date on which excess plan reserves are determined;

(ii) any distribution of excess plan reserves made to or withdrawals made by the nursing facility or a related organization are applicable credits and must be used to reduce the nursing facility's workers' compensation insurance costs in the reporting period in which a distribution or withdrawal is received;

(iii) if reimbursement for the plan is sought under the federal Medicare program, and is audited pursuant to the Medicare program, the nursing facility must provide a copy of Medicare's final audit report, including attachments and exhibits, to the commissioner within 30 days of receipt by the nursing facility or any related organization. The commissioner shall implement the audit findings associated with the plan upon receipt of Medicare's final audit report. The department's authority to implement the audit findings is independent of its authority to conduct a field audit.

(c) In the determination of incremental increases in the nursing facility's rental rate as required in subdivisions 14 to 21, except for a refinancing permitted under subdivision 19, the commissioner must adjust the nursing facility's property-related payment rate for both incremental increases and decreases in recomputations of its rental rate;

(d) A nursing facility's administrative cost limitation must be modified as follows:

(1) if the nursing facility's licensed beds exceed 195 licensed beds, the general and administrative cost category limitation shall be 13 percent;

(2) if the nursing facility's licensed beds are more than 150 licensed beds, but less than 196 licensed beds, the general and administrative cost category limitation shall be 14 percent; or

(3) if the nursing facility's licensed beds is less than 151 licensed beds, the general and administrative cost category limitation shall remain at 15 percent.

(e) For the rate year beginning on July 1, 1998, a group of nursing facilities related by common ownership that self-insures group health, dental, or life insurance may allocate its directly identified costs of self-insuring its Minnesota nursing facility workers among those nursing facilities in the group that are reimbursed under this section or section 256B.434. The method of cost allocation shall be based on the ratio of each nursing facility's total allowable salaries and wages to that of the nursing facility group's total allowable salaries and wages, then similarly allocated within each nursing facility's operating cost categories. The costs associated with the administration of the group's self-insurance plan must remain classified in the nursing facility's administrative cost category. A written request of the nursing facility group's election to use this alternate method of allocation of self-insurance costs must be received by the commissioner no later than May 1, 1998, to take effect July 1, 1998, or those self-insurance costs shall continue to be allocated under the existing cost allocation methods. Once a nursing facility group elects this method of cost allocation for

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its group health, dental, or life insurance self-insurance costs, it shall remain in effect until such time as the group no longer self-insures these costs.

Subd. 23. [Repealed, 2009 c 79 art 8 s 86]

Subd. 24. [Repealed, 2000 c 449 s 15]

Subd. 25. [Repealed, 2012 c 216 art 9 s 38]

Subd. 26. [Repealed, 2012 c 216 art 9 s 38]

Subd. 27. [Repealed, 2012 c 216 art 9 s 38]

Subd. 28. [Repealed, 2014 c 262 art 4 s 9]

Subd. 29. [Repealed, 2012 c 216 art 9 s 38]

Subd. 30. **Bed layaway and delicensure.** (a) For rate years beginning on or after July 1, 2000, a nursing facility reimbursed under this section which has placed beds on layaway shall, for purposes of application of the downsizing incentive in subdivision 3a, paragraph (c), and calculation of the rental per diem, have those beds given the same effect as if the beds had been delicensed so long as the beds remain on layaway. At the time of a layaway, a facility may change its single bed election for use in calculating capacity days under Minnesota Rules, part 9549.0060, subpart 11. The property payment rate increase shall be effective the first day of the month following the month in which the layaway of the beds becomes effective under section 144A.071, subdivision 4b.

(b) For rate years beginning on or after July 1, 2000, notwithstanding any provision to the contrary under section 256B.434, a nursing facility reimbursed under that section which has placed beds on layaway shall, for so long as the beds remain on layaway, be allowed to:

(1) aggregate the applicable investment per bed limits based on the number of beds licensed immediately prior to entering the alternative payment system;

(2) retain or change the facility's single bed election for use in calculating capacity days under Minnesota Rules, part 9549.0060, subpart 11; and

(3) establish capacity days based on the number of beds immediately prior to the layaway and the number of beds after the layaway.

The commissioner shall increase the facility's property payment rate by the incremental increase in the rental per diem resulting from the recalculation of the facility's rental per diem applying only the changes resulting from the layaway of beds and clauses (1), (2), and (3). If a facility reimbursed under section 256B.434 completes a moratorium exception project after its base year, the base year property rate shall be the moratorium project property rate. The base year rate shall be inflated by the factors in section 256B.434, subdivision 4, paragraph (c). The property payment rate increase shall be effective the first day of the month following the month in which the layaway of the beds becomes effective.

(c) If a nursing facility removes a bed from layaway status in accordance with section 144A.071, subdivision 4b, the commissioner shall establish capacity days based on the number of licensed and certified beds in the facility not on layaway and shall reduce the nursing facility's property payment rate in accordance with paragraph (b).

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(d) For the rate years beginning on or after July 1, 2000, notwithstanding any provision to the contrary under section 256B.434, a nursing facility reimbursed under that section, which has delicensed beds after July 1, 2000, by giving notice of the delicensure to the commissioner of health according to the notice requirements in section 144A.071, subdivision 4b, shall be allowed to:

(1) aggregate the applicable investment per bed limits based on the number of beds licensed immediately prior to entering the alternative payment system;

(2) retain or change the facility's single bed election for use in calculating capacity days under Minnesota Rules, part 9549.0060, subpart 11; and

(3) establish capacity days based on the number of beds immediately prior to the delicensure and the number of beds after the delicensure.

The commissioner shall increase the facility's property payment rate by the incremental increase in the rental per diem resulting from the recalculation of the facility's rental per diem applying only the changes resulting from the delicensure of beds and clauses (1), (2), and (3). If a facility reimbursed under section 256B.434 completes a moratorium exception project after its base year, the base year property rate shall be the moratorium project property rate. The base year rate shall be inflated by the factors in section 256B.434, subdivision 4, paragraph (c). The property payment rate increase shall be effective the first day of the month following the month in which the delicensure of the beds becomes effective.

(e) For nursing facilities reimbursed under this section or section 256B.434, any beds placed on layaway shall not be included in calculating facility occupancy as it pertains to leave days defined in Minnesota Rules, part 9505.0415.

(f) For nursing facilities reimbursed under this section or section 256B.434, the rental rate calculated after placing beds on layaway may not be less than the rental rate prior to placing beds on layaway.

(g) A nursing facility receiving a rate adjustment as a result of this section shall comply with section 256B.47, subdivision 2.

(h) A facility that does not utilize the space made available as a result of bed layaway or delicensure under this subdivision to reduce the number of beds per room or provide more common space for nursing facility uses or perform other activities related to the operation of the nursing facility shall have its property rate increase calculated under this subdivision reduced by the ratio of the square footage made available that is not used for these purposes to the total square footage made available as a result of bed layaway or delicensure.

Subd. 31. [Repealed, 2014 c 262 art 4 s 9]

Subd. 32. **Payment during first 30 days.** (a) For rate years beginning on or after July 1, 2011, the total payment rate for a facility reimbursed under this section, section 256B.434, or any other section shall be:

(1) for the first 30 calendar days after admission, the rate shall be 120 percent of the facility's medical assistance rate for each RUG class;

(2) beginning with the 31st calendar day after admission, the payment rate shall be the rate otherwise determined under this section, section 256B.434, or any other section; and

(3) payments under this paragraph apply to admissions occurring on or after July 1, 2011.

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(b) The enhanced rates under this subdivision shall not be allowed if a resident has resided during the previous 30 calendar days in:

(1) the same nursing facility;

(2) a nursing facility owned or operated by a related party; or

(3) a nursing facility or part of a facility that closed or was in the process of closing.

Subd. 33. [Repealed, 2014 c 262 art 4 s 9]

Subd. 34. [Repealed, 2014 c 262 art 4 s 9]

Subd. 35. **Exclusion of raw food cost adjustment.** For rate years beginning on or after July 1, 2001, in calculating a nursing facility's operating cost per diem for the purposes of comparing to an array, a median, or other statistical measure of nursing facility payment rates to be used to determine future rate adjustments under this section, section 256B.434, or any other section, the commissioner shall exclude adjustments for raw food costs under subdivision 2b, paragraph (h), that are related to providing special diets based on religious beliefs.

Subd. 36. **Employee scholarship costs and training in English as a second language.** (a) For the period between July 1, 2001, and June 30, 2003, the commissioner shall provide to each nursing facility reimbursed under this section, section 256B.434, or any other section, a scholarship per diem of 25 cents to the total operating payment rate to be used:

(1) for employee scholarships that satisfy the following requirements:

(i) scholarships are available to all employees who work an average of at least 20 hours per week at the facility except the administrator, department supervisors, and registered nurses; and

(ii) the course of study is expected to lead to career advancement with the facility or in long-term care, including medical care interpreter services and social work; and

(2) to provide job-related training in English as a second language.

(b) A facility receiving a rate adjustment under this subdivision may submit to the commissioner on a schedule determined by the commissioner and on a form supplied by the commissioner a calculation of the scholarship per diem, including: the amount received from this rate adjustment; the amount used for training in English as a second language; the number of persons receiving the training; the name of the person or entity providing the training; and for each scholarship recipient, the name of the recipient, the amount awarded, the educational institution attended, the nature of the educational program, the program completion date, and a determination of the per diem amount of these costs based on actual resident days.

(c) On July 1, 2003, the commissioner shall remove the 25 cent scholarship per diem from the total operating payment rate of each facility.

(d) For rate years beginning after June 30, 2003, the commissioner shall provide to each facility the scholarship per diem determined in paragraph (b). In calculating the per diem under paragraph (b), the commissioner shall allow only costs related to tuition and direct educational expenses.

Subd. 37. [Repealed, 2014 c 262 art 4 s 9]

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Subd. 38. [Repealed, 2014 c 262 art 4 s 9]

Subd. 39. [Repealed, 2014 c 262 art 4 s 9]

Subd. 40. [Repealed, 2014 c 262 art 4 s 9]

Subd. 41. [Repealed, 2014 c 262 art 4 s 9]

Subd. 42. **Incentive to establish single-bed rooms.** (a) Beginning July 1, 2005, the operating payment rate for nursing facilities reimbursed under this section, section 256B.434, or 256B.441 shall be increased by 20 percent multiplied by the ratio of the number of new single-bed rooms created divided by the number of active beds on July 1, 2005, for each bed closure that results in the creation of a single-bed room after July 1, 2005. The commissioner may implement rate adjustments for up to 3,000 new single-bed rooms each year. For eligible bed closures for which the commissioner receives a notice from a facility during a calendar quarter that a bed has been delicensed and a new single-bed room has been established, the rate adjustment in this paragraph shall be effective on the first day of the second month following that calendar quarter.

(b) A nursing facility is prohibited from discharging residents for purposes of establishing single-bed rooms. A nursing facility must submit documentation to the commissioner in a form prescribed by the commissioner, certifying the occupancy status of beds closed to create single-bed rooms. In the event that the commissioner determines that a facility has discharged a resident for purposes of establishing a single-bed room, the commissioner shall not provide a rate adjustment under paragraph (a).

(c) If after August 1, 2005, and before December 31, 2007, more than 4,000 nursing home beds are removed from service, a portion of the appropriation for nursing homes shall be transferred to the alternative care program. The amount of this transfer shall equal the number of beds removed from service less 4,000, multiplied by the average monthly per-person cost for alternative care, multiplied by 12, and further multiplied by 0.3.

Subd. 43. [Repealed, 2014 c 262 art 4 s 9]

Subd. 44. **Property rate increases for certain nursing facilities.** (a) Notwithstanding any other law to the contrary, money available for moratorium projects under section 144A.073, subdivision 11, shall be used, effective November 1, 2010, to fund an approved moratorium exception project for a nursing facility in Bloomington licensed for 137 beds as of November 1, 2010, up to a total property rate adjustment of $19.33.

(b) Effective June 1, 2012, any nursing facility in McLeod County licensed for 110 beds shall have its replacement-cost-new limit under subdivision 17e adjusted to allow $1,129,463 of a completed construction project to increase the property payment rate. Notwithstanding any other law to the contrary, money available under section 144A.073, subdivision 11, after the completion of the moratorium exception approval process in 2013 under section 144A.073, subdivision 3, shall be used to reduce the fiscal impact to the medical assistance budget for the increase in the replacement-cost-new limit.

(c) Effective July 1, 2012, any nursing facility in Dakota County licensed for 61 beds shall have their replacement-cost-new limit under subdivision 17e adjusted to allow $1,407,624 of a completed construction project to increase their property payment rate. Effective September 1, 2013, or later, their replacement-cost-new limit under subdivision 17e shall be adjusted to allow $1,244,599 of a completed construction project to increase the property payment rate. Notwithstanding any other law to the contrary, money available under section 144A.073, subdivision 11, after the completion of the moratorium exception approval process

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in 2013 under section 144A.073, subdivision 3, shall be used to reduce the fiscal impact to the medical assistance budget for the increase in the replacement-cost-new limit.

(d) Effective July 1, 2013, or later, any boarding care facility in Hennepin County licensed for 101 beds shall be allowed to receive a property rate adjustment for a construction project that takes action to come into compliance with Minnesota Department of Labor and Industry elevator upgrade requirements, with costs below the minimum threshold under subdivision 16. Only costs related to the construction project that brings the facility into compliance with the elevator requirements shall be allowed. Notwithstanding any other law to the contrary, money available under section 144A.073, subdivision 11, after the completion of the moratorium exception approval process in 2013 under section 144A.073, subdivision 3, shall be used to reduce the fiscal impact to the medical assistance program.

Subd. 45. **Rate adjustments for some moratorium exception projects.** Notwithstanding any other law to the contrary, money available for moratorium exception projects under section 144A.073, subdivisions 2 and 11, shall be used to fund the incremental rate increases resulting from this section for any nursing facility with a moratorium exception project approved under section 144A.073, and completed after August 30, 2010, where the replacement-costs-new limits under subdivision 17e were higher at any time after project approval than at the time of project completion. The commissioner shall calculate the property rate increase for these facilities using the highest set of limits; however, any rate increase under this section shall not be effective until on or after the effective date of this section, contingent upon federal approval. No property rate decrease shall result from this section.

History: *1983 c 199 s 12; 1984 c 640 s 32; 1984 c 641 s 17-20,22; 1984 c 654 art 5 s 58; 1984 c 655 art 1 s 40,41; 1985 c 248 s 40,69; 1985 c 267 s 3; 1Sp1985 c 3 s 25,27-29,31; 1986 c 316 s 2; 1987 c 403 art 2 s 89; art 4 s 6-11; 1988 c 689 art 2 s 154-161; 1988 c 719 art 19 s 9; 1989 c 12 s 1,2; 1989 c 282 art 3 s 66-78; 1990 c 568 art 3 s 65-72; 1991 c 292 art 4 s 54-60; art 6 s 49,50; art 7 s 25; 1992 c 464 art 1 s 29; 1992 c 513 art 7 s 88-103,136; 1992 c 603 s 19; 1993 c 339 s 20; 1Sp1993 c 1 art 5 s 90-99; 1995 c 207 art 6 s 85,86; art 7 s 23-26; 1996 c 305 art 2 s 48; 1996 c 451 art 3 s 3; 1997 c 2 s 10; 1997 c 107 s 8; 1997 c 187 art 3 s 29; 1997 c 203 art 3 s 7,8; art 4 s 46; 1998 c 407 art 3 s 4-11; art 4 s 42; 1999 c 245 art 3 s 17-20; 2000 c 271 s 1; 2000 c 294 s 2; 2000 c 449 s 3-12; 2000 c 488 art 9 s 18-21; 2000 c 499 s 23; 1Sp2001 c 9 art 5 s 15-21; art 6 s 6; 2002 c 220 art 14 s 9,10; 2002 c 277 s 32; 2002 c 374 art 10 s 5,6; 2002 c 375 art 2 s 35-38; 2002 c 379 art 1 s 113; 2003 c 9 s 2; 2003 c 16 s 2; 1Sp2003 c 14 art 2 s 30-35; 2004 c 194 s 1; 2004 c 288 art 5 s 7,8; 2005 c 10 art 1 s 54; 2005 c 56 s 1; 2005 c 151 art 2 s 17; 1Sp2005 c 4 art 7 s 33,34; 2006 c 282 art 20 s 20; 2007 c 147 art 6 s 41-44; art 7 s 19,20; 2008 c 363 art 15 s 9; 2009 c 101 art 2 s 109; 2009 c 159 s 96; 2010 c 394 s 1; 2011 c 22 art 1 s 6; art 2 s 2; 1Sp2011 c 9 art 7 s 25-27; 2012 c 247 art 4 s 29,30; 2013 c 108 art 7 s 23; 2014 c 275 art 1 s 64,140*

256B.432 LONG-TERM CARE FACILITIES; OFFICE COSTS.

Subdivision 1. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Management agreement" means an agreement in which one or more of the following criteria exist:

(1) the central, affiliated, or corporate office has or is authorized to assume day-to-day operational control of the nursing facility for any six-month period within a 24-month period. "Day-to-day operational control" means that the central, affiliated, or corporate office has the authority to require, mandate, direct, or compel the employees of the nursing facility to perform or refrain from performing certain acts, or to supplant or take the place of the top management of the nursing facility. "Day-to-day operational control"

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includes the authority to hire or terminate employees or to provide an employee of the central, affiliated, or corporate office to serve as administrator of the nursing facility;

(2) the central, affiliated, or corporate office performs or is authorized to perform two or more of the following: the execution of contracts; authorization of purchase orders; signature authority for checks, notes, or other financial instruments; requiring the nursing facility to use the group or volume purchasing services of the central, affiliated, or corporate office; or the authority to make annual capital expenditures for the nursing facility exceeding $50,000, or $500 per licensed bed, whichever is less, without first securing the approval of the nursing facility board of directors;

(3) the central, affiliated, or corporate office becomes or is required to become the licensee under applicable state law;

(4) the agreement provides that the compensation for services provided under the agreement is directly related to any profits made by the nursing facility; or

(5) the nursing facility entering into the agreement is governed by a governing body that meets fewer than four times a year, that does not publish notice of its meetings, or that does not keep formal records of its proceedings.

(b) "Consulting agreement" means any agreement the purpose of which is for a central, affiliated, or corporate office to advise, counsel, recommend, or suggest to the owner or operator of the nonrelated nursing facility measures and methods for improving the operations of the nursing facility.

(c) "Nursing facility" means a facility with a medical assistance provider agreement that is licensed as a nursing home under chapter 144A or as a boarding care home under sections 144.50 to 144.56.

Subd. 2. **Effective date.** For rate years beginning on or after July 1, 1990, the central, affiliated, or corporate office cost allocations in subdivisions 3 to 6 must be used when determining medical assistance rates under section 256B.431, 256B.434, or 256B.441.

Subd. 3. **Allocation; direct identification of costs; management agreement.** All costs that can be directly identified with a specific nursing facility that is a related organization to the central, affiliated, or corporate office, or that is controlled by the central, affiliated, or corporate office under a management agreement, must be allocated to that nursing facility.

Subd. 4. **Allocation; direct identification of costs to other activities.** All costs that can be directly identified with any other activity or function not described in subdivision 3 must be allocated to that activity or function.

Subd. 4a. **Cost allocation on a functional basis.** (a) Costs that have not been directly identified must be allocated to nursing facilities on a basis designed to equitably allocate the costs to the nursing facilities or activities receiving the benefits of the costs. This allocation must be made in a manner reasonably related to the services received by the nursing facilities. Where practical and the amounts are material, these costs must be allocated on a functional basis. The functions, or cost centers used to allocate central office costs, and the unit bases used to allocate the costs, including those central office costs allocated according to subdivision 5, must be used consistently from one central office accounting period to another.

(b) If the central office wishes to change its allocation bases and believes the change will result in more appropriate and more accurate allocations, the central office must make a written request, with its

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justification, to the commissioner for approval of the change no later than 120 days after the beginning of the central office accounting period to which the change is to apply. The commissioner's approval of a central office request will be furnished to the central office in writing. Where the commissioner approves the central office request, the change must be applied to the accounting period for which the request was made, and to all subsequent central office accounting periods unless the commissioner approves a subsequent request for change by the central office. The effective date of the change will be the beginning of the accounting period for which the request was made.

Subd. 5. **Allocation of remaining costs; allocation ratio.** (a) After the costs that can be directly identified according to subdivisions 3 and 4 have been allocated, the remaining central, affiliated, or corporate office costs must be allocated between the nursing facility operations and the other activities or facilities unrelated to the nursing facility operations based on the ratio of total operating costs. However, in the event that these remaining costs are partially attributable to the start-up of home and community-based services intended to fill a gap identified by the local agency, the facility may assign these remaining costs to the appropriate cost category of the facility for a period not to exceed two years.

(b) For purposes of allocating these remaining central, affiliated, or corporate office costs, the numerator for the allocation ratio shall be determined as follows:

(1) for nursing facilities that are related organizations or are controlled by a central, affiliated, or corporate office under a management agreement, the numerator of the allocation ratio shall be equal to the sum of the total operating costs incurred by each related organization or controlled nursing facility;

(2) for a central, affiliated, or corporate office providing goods or services to related organizations that are not nursing facilities, the numerator of the allocation ratio shall be equal to the sum of the total operating costs incurred by the nonnursing facility related organizations;

(3) for a central, affiliated, or corporate office providing goods or services to unrelated nursing facilities under a consulting agreement, the numerator of the allocation ratio shall be equal to the greater of directly identified central, affiliated, or corporate costs or the contracted amount; or

(4) for business activities that involve the providing of goods or services to unrelated parties which are not nursing facilities, the numerator of the allocation ratio shall be equal to the greater of directly identified costs or revenues generated by the activity or function.

(c) The denominator for the allocation ratio is the sum of the numerators in paragraph (b), clauses (1) to (4).

Subd. 6. **Cost allocation between nursing facilities.** (a) Those nursing operations that have nursing facilities both in Minnesota and comparable facilities outside of Minnesota must allocate the nursing operation's central, affiliated, or corporate office costs identified in subdivision 5 to Minnesota based on the ratio of total resident days in Minnesota nursing facilities to the total resident days in all facilities.

(b) The Minnesota nursing operation's central, affiliated, or corporate office costs identified in paragraph (a) must be allocated to each Minnesota nursing facility on the basis of resident days.

Subd. 6a. **Related organization costs.** (a) Costs applicable to services, capital assets, and supplies directly or indirectly furnished to the nursing facility by any related organization are includable in the allowable cost of the nursing facility at the purchase price paid by the related organization for capital assets

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or supplies and at the cost incurred by the related organization for the provision of services to the nursing facility if these prices or costs do not exceed the price of comparable services, capital assets, or supplies that could be purchased elsewhere. For this purpose, the related organization's costs must not include an amount for markup or profit.

(b) If the related organization in the normal course of business sells services, capital assets, or supplies to nonrelated organizations, the cost to the nursing facility shall be the nonrelated organization's price provided that sales to nonrelated organizations constitute at least 50 percent of total annual sales of similar services, capital assets, or supplies.

Subd. 7. **Receiverships.** This section does not apply to payment rates determined under sections 245A.12, 245A.13, and 256B.495, except that any additional directly identified costs associated with the Department of Human Services' or the department of health's managing agent under a receivership agreement must be allocated to the facility under receivership, and are nonallowable costs to the managing agent on the facility's cost reports.

Subd. 8. **Adequate documentation supporting long-term care facility payrolls.** Beginning July 1, 1998, payroll records supporting compensation costs claimed by long-term care facilities must be supported by affirmative time and attendance records prepared by each individual at intervals of not more than one month. The requirements of this subdivision are met when documentation is provided under either clause (1) or (2) as follows:

(1) the affirmative time and attendance record must identify the individual's name; the days worked during each pay period; the number of hours worked each day; and the number of hours taken each day by the individual for vacation, sick, and other leave. The affirmative time and attendance record must include a signed verification by the individual and the individual's supervisor, if any, that the entries reported on the record are correct; or

(2) if the affirmative time and attendance records identifying the individual's name, the days worked each pay period, the number of hours worked each day, and the number of hours taken each day by the individual for vacation, sick, and other leave are placed on microfilm, equipment must be made available for viewing and printing them, or if the records are stored as automated data, summary data must be available for viewing and printing.

History: *1990 c 568 art 3 s 73; 1992 c 513 art 7 s 104,136; 1Sp1993 c 1 art 5 s 100,101; 1995 c 207 art 7 s 27-31; 1996 c 451 art 5 s 27; 1998 c 274 s 1; 1Sp2005 c 4 art 7 s 35-39*

256B.433 ANCILLARY SERVICES.

Subdivision 1. **Setting payment; monitoring use of therapy services.** The commissioner shall adopt rules under the Administrative Procedure Act to set the amount and method of payment for ancillary materials and services provided to recipients residing in nursing facilities. Payment for materials and services may be made to either the vendor of ancillary services pursuant to Minnesota Rules, parts 9505.0170 to 9505.0475, or to a nursing facility pursuant to Minnesota Rules, parts 9505.0170 to 9505.0475. Payment for the same or similar service to a recipient shall not be made to both the nursing facility and the vendor. The commissioner shall ensure the avoidance of double payments through audits and adjustments to the nursing facility's annual cost report as required by section 256B.47, and that charges and arrangements for ancillary materials and services are cost-effective and as would be incurred by a prudent and cost-conscious buyer. Therapy services provided to a recipient must be medically necessary and appropriate

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to the medical condition of the recipient. If the vendor, nursing facility, or ordering physician cannot provide adequate medical necessity justification, as determined by the commissioner, the commissioner may recover or disallow the payment for the services and may require prior authorization for therapy services as a condition of payment or may impose administrative sanctions to limit the vendor, nursing facility, or ordering physician's participation in the medical assistance program. If the provider number of a nursing facility is used to bill services provided by a vendor of therapy services that is not related to the nursing facility by ownership, control, affiliation, or employment status, no withholding of payment shall be imposed against the nursing facility for services not medically necessary except for funds due the unrelated vendor of therapy services as provided in subdivision 3, paragraph (c). For the purpose of this subdivision, no monetary recovery may be imposed against the nursing facility for funds paid to the unrelated vendor of therapy services as provided in subdivision 3, paragraph (c), for services not medically necessary. For purposes of this section and section 256B.47, therapy includes physical therapy, occupational therapy, speech therapy, audiology, and mental health services that are covered services according to Minnesota Rules, parts 9505.0170 to 9505.0475. For purposes of this subdivision, "ancillary services" includes transportation defined as a covered service in section 256B.0625, subdivision 17.

Subd. 2. **Certification that treatment is appropriate.** The physical therapist, occupational therapist, speech therapist, mental health professional, or audiologist who provides or supervises the provision of therapy services, other than an initial evaluation, to a medical assistance recipient must certify in writing that the therapy's nature, scope, duration, and intensity are appropriate to the medical condition of the recipient every 30 days. The therapist's statement of certification must be maintained in the recipient's medical record together with the specific orders by the physician and the treatment plan. If the recipient's medical record does not include these documents, the commissioner may recover or disallow the payment for such services. If the therapist determines that the therapy's nature, scope, duration, or intensity is not appropriate to the medical condition of the recipient, the therapist must provide a statement to that effect in writing to the nursing facility for inclusion in the recipient's medical record. The commissioner shall utilize a peer review program that meets the requirements of section 256B.064, subdivision 1a, to make recommendations regarding the medical necessity of services provided.

Subd. 3. **Separate billings for therapy services.** Until new procedures are developed under subdivision 4, payment for therapy services provided to nursing facility residents that are billed separate from nursing facility's payment rate or according to Minnesota Rules, parts 9505.0170 to 9505.0475, shall be subject to the following requirements:

(a) The practitioner invoice must include, in a format specified by the commissioner, the provider number of the nursing facility where the medical assistance recipient resides regardless of the service setting.

(b) Nursing facilities that are related by ownership, control, affiliation, or employment status to the vendor of therapy services shall report, in a format specified by the commissioner, the revenues received during the reporting year for therapy services provided to residents of the nursing facility. For rate years beginning on or after July 1, 1988, the commissioner shall offset the revenues received during the reporting year for therapy services provided to residents of the nursing facility to the total payment rate of the nursing facility by dividing the amount of offset by the nursing facility's actual resident days. Except as specified in paragraphs (d) and (f), the amount of offset shall be the revenue in excess of 108 percent of the cost removed from the cost report resulting from the requirement of the commissioner to ensure the avoidance of double payments as determined by section 256B.47. Therapy revenues that are specific to mental health services shall be subject to this paragraph for rate years beginning after June 30, 1993. In establishing a new base period for the purpose of setting operating cost payment rate limits and rates, the commissioner shall not include the revenues offset in accordance with this section.

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(c) For rate years beginning on or after July 1, 1987, nursing facilities shall limit charges in total to vendors of therapy services for renting space, equipment, or obtaining other services during the rate year to 108 percent of the annualized cost removed from the reporting year cost report resulting from the requirement of the commissioner to ensure the avoidance of double payments as determined by section 256B.47. If the arrangement for therapy services is changed so that a nursing facility is subject to this paragraph instead of paragraph (b), the cost that is used to determine rent must be adjusted to exclude the annualized costs for therapy services that are not provided in the rate year. The maximum charges to the vendors shall be based on the commissioner's determination of annualized cost and may be subsequently adjusted upon resolution of appeals. Mental health services shall be subject to this paragraph for rate years beginning after June 30, 1993.

(d) The commissioner shall require reporting of all revenues relating to the provision of therapy services and shall establish a therapy cost, as determined by section 256B.47, to revenue ratio for the reporting year ending in 1986. For subsequent reporting years, the ratio may increase five percentage points in total until a new base year is established under paragraph (e). Increases in excess of five percentage points may be allowed if adequate justification is provided to and accepted by the commissioner. Unless an exception is allowed by the commissioner, the amount of offset in paragraph (b) is the greater of the amount determined in paragraph (b) or the amount of offset that is imputed based on one minus the lesser of (1) the actual reporting year ratio or (2) the base reporting year ratio increased by five percentage points, multiplied by the revenues.

(e) The commissioner may establish a new reporting year base for determining the cost to revenue ratio.

(f) If the arrangement for therapy services is changed so that a nursing facility is subject to the provisions of paragraph (b) instead of paragraph (c), an average cost to revenue ratio based on the ratios of nursing facilities that are subject to the provisions of paragraph (b) shall be imputed for paragraph (d).

(g) This section does not allow unrelated nursing facilities to reorganize related organization therapy services and provide services among themselves to avoid offsetting revenues. Nursing facilities that are found to be in violation of this provision shall be subject to the penalty requirements of section 256B.48, subdivision 1, paragraph (f).

Subd. 3a. **Exemption from requirement for separate therapy billing.** The provisions of subdivision 3 do not apply to nursing facilities that are reimbursed according to the provisions of section 256B.431. Nursing facilities that are reimbursed according to the provisions of section 256B.434 and are located in a county participating in the prepaid medical assistance program are exempt from the maximum therapy rent revenue provisions of subdivision 3, paragraph (c).

Subd. 4. [Repealed, 1993 c 337 s 20]

History: *1983 c 199 s 18; 1985 c 248 s 69; 1987 c 403 art 2 s 90; 1988 c 629 s 54,55; 1988 c 689 art 2 s 162; 1992 c 513 art 7 s 105-107,136; 1993 c 337 s 17; 1997 c 203 art 3 s 9; 1998 c 407 art 3 s 12; 1Sp2001 c 9 art 5 s 22; 2002 c 379 art 1 s 113; 2009 c 159 s 97*

256B.434 ALTERNATIVE PAYMENT DEMONSTRATION PROJECT.

Subdivision 1. **Alternative payment demonstration project established.** The commissioner of human services shall establish a contractual alternative payment demonstration project for paying for nursing facility services under the medical assistance program. A nursing facility may apply to be paid under the contractual alternative payment demonstration project instead of the cost-based payment system established

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under section 256B.431. A nursing facility electing to use the alternative payment demonstration project must enter into a contract with the commissioner. Payment rates and procedures for facilities electing to use the alternative payment demonstration project are determined and governed by this section and by the terms of the contract. The commissioner may negotiate different contract terms for different nursing facilities.

Subd. 2. **Requests for proposals.** (a) At least twice annually the commissioner shall publish in the State Register a request for proposals to provide nursing facility services according to this section. The commissioner must respond to all proposals in a timely manner.

(b) The commissioner may reject any proposal if, in the judgment of the commissioner, a contract with a particular facility is not in the best interests of the residents of the facility or the state of Minnesota. The commissioner may accept up to the number of proposals that can be adequately supported with available state resources, as determined by the commissioner. The commissioner may accept proposals from a single nursing facility or from a group of facilities through a managing entity. The commissioner shall seek to ensure that nursing facilities under contract are located in all geographic areas of the state.

(c) In issuing the 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 contractual alternative payment demonstration project furthers the interest of the state of Minnesota. The request for proposals may include, but need not be limited to, the following:

(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 a project to develop 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. Revenue generated from the fees is appropriated to the commissioner and must be used to contract with a qualified consultant or contractor to develop data collection systems and outcome-based contracting standards;

(5) a requirement that contractors agree to maintain Medicare cost reports and to submit them to the commissioner upon request or at times specified by the commissioner;

(6) a requirement for demonstrated willingness and ability to develop and maintain data collection and retrieval systems to be used in measuring 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 in determining whether to accept or deny a proposal:

(1) the facility's history of compliance with federal and state laws and rules, except that a facility deemed to be in substantial compliance with federal and state laws and rules is eligible to respond to a request for

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proposal. 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) financial history and solvency; and

(4) other factors identified by the commissioner that the commissioner deems relevant to 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) If the commissioner rejects the proposal of a nursing facility, the commissioner shall provide written notice to the facility of the reason for the rejection, including the factors and evidence upon which the rejection was based.

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 not to exceed four years. 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 terms of up to four years, unless either party provides written notice of termination. The provisions of the contract shall be renegotiated at a minimum of every four years 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 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, the commissioner shall establish a rate under this subdivision. The nursing facility must enter into a written contract with the commissioner.

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

(c) A nursing facility's case mix payment rates for the second and subsequent years of a facility's contract under this section are the previous rate year's contract payment rates plus an inflation adjustment and, for facilities reimbursed under this section or section 256B.431, an adjustment to include the cost of any increase in Health Department licensing fees for the facility taking effect on or after July 1, 2001. The index for the inflation adjustment must be based on the change in the Consumer Price Index-All Items (United States City average) (CPI-U) forecasted by the commissioner of management and budget's national economic consultant, as forecasted in the fourth quarter of the calendar year preceding the rate year. The inflation

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adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined. For the rate years beginning on July 1, 1999, July 1, 2000, July 1, 2001, July 1, 2002, July 1, 2003, July 1, 2004, July 1, 2005, July 1, 2006, July 1, 2007, July 1, 2008, October 1, 2009, and October 1, 2010, this paragraph shall apply only to the property-related payment rate. For the rate years beginning on October 1, 2011, October 1, 2012, October 1, 2013, October 1, 2014, October 1, 2015, and October 1, 2016, the rate adjustment under this paragraph shall be suspended. Beginning in 2005, adjustment to the property payment rate under this section and section 256B.431 shall be effective on October 1. 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 a facility's operating payment rate for achieving outcomes specified in a contract. The commissioner may solicit contract amendments and implement those which, on a competitive basis, best meet the state's policy objectives. The commissioner shall limit the amount of any incentive payment and the number of contract amendments under this paragraph to operate the incentive payments within funds appropriated for this purpose. The contract amendments may specify various levels of payment for various levels of performance. Incentive payments to facilities under this paragraph may be in the form of time-limited rate adjustments or onetime supplemental payments. In establishing the specified outcomes and related criteria, the commissioner shall consider the following state policy objectives:

(1) successful diversion or discharge of residents to the residents' prior home or other community-based alternatives;

(2) adoption of new technology to improve quality or efficiency;

(3) improved quality as measured in the Nursing Home Report Card;

(4) reduced acute care costs; and

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

(e) Notwithstanding the threshold in section 256B.431, subdivision 16, facilities that take action to come into compliance with existing or pending requirements of the life safety code provisions or federal regulations governing sprinkler systems must receive reimbursement for the costs associated with compliance if all of the following conditions are met:

(1) the expenses associated with compliance occurred on or after January 1, 2005, and before December 31, 2008;

(2) the costs were not otherwise reimbursed under subdivision 4f or section 144A.071 or 144A.073; and

(3) the total allowable costs reported under this paragraph are less than the minimum threshold established under section 256B.431, subdivision 15, paragraph (e), and subdivision 16.

The commissioner shall use money appropriated for this purpose to provide to qualifying nursing facilities a rate adjustment beginning October 1, 2007, and ending September 30, 2008. Nursing facilities that have spent money or anticipate the need to spend money to satisfy the most recent life safety code requirements by (1) installing a sprinkler system or (2) replacing all or portions of an existing sprinkler system may submit to the commissioner by June 30, 2007, on a form provided by the commissioner the actual costs of a

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completed project or the estimated costs, based on a project bid, of a planned project. The commissioner shall calculate a rate adjustment equal to the allowable costs of the project divided by the resident days reported for the report year ending September 30, 2006. If the costs from all projects exceed the appropriation for this purpose, the commissioner shall allocate the money appropriated on a pro rata basis to the qualifying facilities by reducing the rate adjustment determined for each facility by an equal percentage. Facilities that used estimated costs when requesting the rate adjustment shall report to the commissioner by January 31, 2009, on the use of this money on a form provided by the commissioner. If the nursing facility fails to provide the report, the commissioner shall recoup the money paid to the facility for this purpose. If the facility reports expenditures allowable under this subdivision that are less than the amount received in the facility's annualized rate adjustment, the commissioner shall recoup the difference.

Subd. 4a. [Repealed, 2012 c 216 art 9 s 38]

Subd. 4b. [Repealed, 2012 c 216 art 9 s 38]

Subd. 4c. [Repealed, 2012 c 216 art 9 s 38]

Subd. 4d. [Repealed, 2012 c 216 art 9 s 38]

Subd. 4e. [Repealed, 2012 c 216 art 9 s 38]

Subd. 4f. **Construction project rate adjustments effective October 1, 2006.** (a) Effective October 1, 2006, facilities reimbursed under this section may receive a property rate adjustment for construction projects exceeding the threshold in section 256B.431, subdivision 16, and below the threshold in section 144A.071, subdivision 2, clause (a). For these projects, capital assets purchased shall be counted as construction project costs for a rate adjustment request made by a facility if they are: (1) purchased within 24 months of the completion of the construction project; (2) purchased after the completion date of any prior construction project; and (3) are not purchased prior to July 14, 2005. Except as otherwise provided in this subdivision, the definitions, rate calculation methods, and principles in sections 144A.071 and 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, shall be used to calculate rate adjustments for allowable construction projects under this subdivision and section 144A.073. Facilities completing construction projects between October 1, 2005, and October 1, 2006, are eligible to have a property rate adjustment effective October 1, 2006. Facilities completing projects after October 1, 2006, are eligible for a property rate adjustment effective on the first day of the month following the completion date.

(b) Notwithstanding subdivision 18, as of July 14, 2005, facilities with rates set under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, that commenced a construction project on or after October 1, 2004, and do not have a contract under subdivision 3 by September 30, 2006, are eligible to request a rate adjustment under section 256B.431, subdivision 10, through September 30, 2006. If the request results in the commissioner determining a rate adjustment is allowable, the rate adjustment is effective on the first of the month following project completion. These facilities shall be allowed to accumulate construction project costs for the period October 1, 2004, to September 30, 2006.

(c) Facilities shall be allowed construction project rate adjustments no sooner than 12 months after completing a previous construction project. Facilities must request the rate adjustment according to section 256B.431, subdivision 10.

(d) Capacity days shall be computed according to Minnesota Rules, part 9549.0060, subpart 11. For rate calculations under this section, the number of licensed beds in the nursing facility shall be the number

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existing after the construction project is completed and the number of days in the nursing facility's reporting period shall be 365.

(e) The value of assets to be recognized for a total replacement project as defined in section 256B.431, subdivision 17d, shall be computed as described in clause (1). The value of assets to be recognized for all other projects shall be computed as described in clause (2).

(1) Replacement-cost-new limits under section 256B.431, subdivision 17e, and the number of beds allowed under subdivision 3a, paragraph (c), shall be used to compute the maximum amount of assets allowable in a facility's property rate calculation. If a facility's current request for a rate adjustment results from the completion of a construction project that was previously approved under section 144A.073, the assets to be used in the rate calculation cannot exceed the lesser of the amount determined under sections 144A.071, subdivision 2, and 144A.073, subdivision 3b, or the actual allowable costs of the construction project. A current request that is not the result of a project under section 144A.073 cannot exceed the limit under section 144A.071, subdivision 2, paragraph (a). Applicable credits must be deducted from the cost of the construction project.

(2)(i) Replacement-cost-new limits under section 256B.431, subdivision 17e, and the number of beds allowed under section 256B.431, subdivision 3a, paragraph (c), shall be used to compute the maximum amount of assets allowable in a facility's property rate calculation.

(ii) The value of a facility's assets to be compared to the amount in item (i) begins with the total appraised value from the last rate notice a facility received when its rates were set under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080. This value shall be indexed by the factor in section 256B.431, subdivision 3f, paragraph (a), for each rate year the facility received an inflation factor on its property-related rate when its rates were set under this section. The value of assets listed as previous capital additions, capital additions, and special projects on the facility's base year rate notice and the value of assets related to a construction project for which the facility received a rate adjustment when its rates were determined under this section shall be added to the indexed appraised value.

(iii) The maximum amount of assets to be recognized in computing a facility's rate adjustment after a project is completed is the lesser of the aggregate replacement-cost-new limit computed in (i) minus the assets recognized in (ii) or the actual allowable costs of the construction project.

(iv) If a facility's current request for a rate adjustment results from the completion of a construction project that was previously approved under section 144A.073, the assets to be added to the rate calculation cannot exceed the lesser of the amount determined under sections 144A.071, subdivision 2, and 144A.073, subdivision 3b, or the actual allowable costs of the construction project. A current request that is not the result of a project under section 144A.073 cannot exceed the limit stated in section 144A.071, subdivision 2, paragraph (a). Assets disposed of as a result of a construction project and applicable credits must be deducted from the cost of the construction project.

(f) For construction projects approved under section 144A.073, allowable debt may never exceed the lesser of the cost of the assets purchased, the threshold limit in section 144A.071, subdivision 2, or the replacement-cost-new limit less previously existing capital debt.

(g) For construction projects that were not approved under section 144A.073, allowable debt is limited to the lesser of the threshold in section 144A.071, subdivision 2, for such construction projects or the applicable limit in paragraph (e), clause (1) or (2), less previously existing capital debt. Amounts of debt taken out that exceed the costs of a construction project shall not be allowed regardless of the use of the funds.

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For all construction projects being recognized, interest expense and average debt shall be computed based on the first 12 months following project completion. "Previously existing capital debt" means capital debt recognized on the last rate determined under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, and the amount of debt recognized for a construction project for which the facility received a rate adjustment when its rates were determined under this section.

For a total replacement project as defined in section 256B.431, subdivision 17d, the value of previously existing capital debt shall be zero.

(h) In addition to the interest expense allowed from the application of paragraph (f), the amounts allowed under section 256B.431, subdivision 17a, paragraph (a), clauses (2) and (3), will be added to interest expense.

(i) The equity portion of the construction project shall be computed as the allowable assets in paragraph (e), less the average debt in paragraph (f). The equity portion must be multiplied by 5.66 percent and the allowable interest expense in paragraph (f) must be added. This sum must be divided by 95 percent of capacity days to compute the construction project rate adjustment.

(j) For projects that are not a total replacement of a nursing facility, the amount in paragraph (i) is adjusted for nonreimbursable areas and then added to the current property payment rate of the facility.

(k) For projects that are a total replacement of a nursing facility, the amount in paragraph (i) becomes the new property payment rate after being adjusted for nonreimbursable areas. Any amounts existing in a facility's rate before the effective date of the construction project for equity incentives under section 256B.431, subdivision 16; capital repairs and replacements under section 256B.431, subdivision 15; or refinancing incentives under section 256B.431, subdivision 19, shall be removed from the facility's rates.

(l) No additional equipment allowance is allowed under Minnesota Rules, part 9549.0060, subpart 10, as the result of construction projects under this section. Allowable equipment shall be included in the construction project costs.

(m) Capital assets purchased after the completion date of a construction project shall be counted as construction project costs for any future rate adjustment request made by a facility under section 144A.071, subdivision 2, clause (a), if they are purchased within 24 months of the completion of the future construction project.

(n) In subsequent rate years, the property payment rate for a facility that results from the application of this subdivision shall be the amount inflated in subdivision 4.

(o) Construction projects are eligible for an equity incentive under section 256B.431, subdivision 16. When computing the equity incentive for a construction project under this subdivision, only the allowable costs and allowable debt related to the construction project shall be used. The equity incentive shall not be a part of the property payment rate and not inflated under subdivision 4. Effective October 1, 2006, all equity incentives for nursing facilities reimbursed under this section shall be allowed for a duration determined under section 256B.431, subdivision 16, paragraph (c).

Subd. 4g. [Repealed, 2012 c 216 art 9 s 38]

Subd. 4h. [Repealed, 2012 c 216 art 9 s 38]

Subd. 5. [Repealed, 1Sp2001 c 9 art 5 s 41]

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Subd. 6. **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 the alternative payment demonstration project, 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 in accordance with the appeal decision.

Subd. 7. [Repealed, 2012 c 216 art 9 s 38]

Subd. 8. [Repealed, 2012 c 216 art 9 s 38]

Subd. 9. **Managed care contracts for other services.** Beginning July 1, 1995, the commissioner may contract with nursing facilities that have entered into alternative payment demonstration project contracts under this section to provide medical assistance services other than nursing facility care to residents of the facility under a prepaid, managed care payment system. Managed care contracts for other services may be entered into at any time during the duration of a nursing facility's alternative payment demonstration project contract, and the terms of the managed care contracts need not coincide with the terms of the alternative payment demonstration project contract.

Subd. 10. **Exemptions.** (a) To the extent permitted by federal law, (1) a facility that has entered into a contract under this section is not required to file a cost report, as defined in Minnesota Rules, part 9549.0020, subpart 13, for any year after the base year that is the basis for the calculation of the contract payment rate for the first rate year of the alternative payment demonstration project contract; and (2) a facility under contract is not subject to audits of historical costs or revenues, or paybacks or retroactive adjustments based on these costs or revenues, except audits, paybacks, or adjustments relating to the cost report that is the basis for calculation of the first rate year under the contract.

(b) A facility that is under contract with the commissioner under this section is not subject to the moratorium on licensure or certification of new nursing home beds in section 144A.071, unless the project results in a net increase in bed capacity or involves relocation of beds from one site to another. Contract payment rates must not be adjusted to reflect any additional costs that a nursing facility incurs as a result of a construction project undertaken under this paragraph. In addition, as a condition of entering into a contract under this section, a nursing facility must agree that any future medical assistance payments for nursing facility services will not reflect any additional costs attributable to the sale of a nursing facility under this section and to construction undertaken under this paragraph that otherwise would not be authorized under the moratorium in section 144A.073. Nothing in this section prevents a nursing facility participating in the alternative payment demonstration project under this section from seeking approval of an exception to the moratorium through the process established in section 144A.073, and if approved the facility's rates shall be adjusted to reflect the cost of the project. Nothing in this section prevents a nursing facility participating in the alternative payment demonstration project from seeking legislative approval of an exception to the moratorium under section 144A.071, and, if enacted, the facility's rates shall be adjusted to reflect the cost of the project.

(c) Notwithstanding paragraph (a), if by April 1, 1996, the health care financing administration has not approved a required waiver, or the Centers for Medicare and Medicaid Services otherwise requires cost reports to be filed prior to the waiver's approval, the commissioner shall require a cost report for the rate year.

(d) A facility that is under contract with the commissioner under this section shall be allowed to change therapy arrangements from an unrelated vendor to a related vendor during the term of the contract. The commissioner may develop reasonable requirements designed to prevent an increase in therapy utilization for residents enrolled in the medical assistance program.

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(e) Nursing facilities participating in the alternative payment system demonstration project must either participate in the alternative payment system quality improvement program established by the commissioner or submit information on their own quality improvement process to the commissioner for approval. Nursing facilities that have had their own quality improvement process approved by the commissioner must report results for at least one key area of quality improvement annually to the commissioner.

Subd. 11. **Consumer protection.** As a condition of entering into a contract under this section, a nursing facility must agree to establish resident grievance procedures that are similar to those required under section 256.045, subdivision 3. The commissioner may also require nursing facilities to establish expedited grievance procedures to resolve complaints made by short-stay residents. The facility must notify its resident council of its intent to enter into a contract and must consult with the council regarding any changes in operation expected as a result of the contract.

Subd. 12. **Contracts are voluntary.** Participation of nursing facilities in the alternative payment demonstration project is voluntary. The terms and procedures governing the alternative payment demonstration project are determined under this section and through negotiations between the commissioner and nursing facilities that have submitted a letter of intent to participate in the alternative demonstration project. For purposes of developing requests for proposals and contract requirements, and negotiating the terms, conditions, and requirements of contracts the commissioner is exempt from the rulemaking requirements in chapter 14 until December 31, 2000.

Subd. 13. [Repealed, 2001 c 161 s 58]

Subd. 14. **Federal requirements.** The commissioner shall implement the contractual alternative payment demonstration project 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.

Subd. 15. **External review panel.** The commissioner may establish an external review panel consisting of persons appointed by the commissioner for their expertise on issues relating to nursing facility services, quality, payment systems, and other matters, to advise the commissioner on the development and implementation of the contractual alternative payment demonstration project and to assist the commissioner in assessing the quality of care provided and evaluating a facility's compliance with performance standards specified in a contract. The external review panel must include, among other members, representatives of nursing facilities.

Subd. 16. **Alternative contracts.** 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.

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

Subd. 18. **Facilities without APS contracts as of October 1, 2006.** Effective October 1, 2006, payment rates for property shall no longer be determined under section 256B.431. A facility that does not have a contract with the commissioner under this section shall not be eligible for a rate increase.

Subd. 19. [Repealed, 2014 c 262 art 4 s 9]

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Subd. 19a. **Nursing facility rate adjustments beginning September 1, 2013.** A total of a five percent average rate adjustment shall be provided as described under this subdivision and under section 256B.441, subdivision 46b.

(a) Beginning September 1, 2013, the commissioner shall make available to each nursing facility reimbursed under this section a 3.75 percent operating payment rate increase, in accordance with paragraphs (b) to (g).

(b) Seventy-five percent of the money resulting from the rate adjustment under paragraph (a) must be used for increases in compensation-related costs for employees directly employed by the nursing facility on or after the effective date of the rate adjustment, except:

(1) the administrator;

(2) persons employed in the central office of a corporation that has an ownership interest in the nursing facility or exercises control over the nursing facility; and

(3) persons paid by the nursing facility under a management contract.

(c) The commissioner shall allow as compensation-related costs all costs for:

(1) wage and salary increases effective after May 25, 2013;

(2) the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, and workers' compensation;

(3) the employer's share of health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, and pensions; and

(4) other benefits provided and workforce needs, including the recruiting and training of employees, subject to the approval of the commissioner.

(d) The portion of the rate adjustment under paragraph (a) that is not subject to the requirements of paragraph (b) shall be provided to nursing facilities effective September 1, 2013. Nursing facilities may apply for the portion of the rate adjustment under paragraph (a) that is subject to the requirements in paragraph (b). The application must be submitted to the commissioner within six months of the effective date of the rate adjustment, and the nursing facility must provide additional information required by the commissioner within nine months of the effective date of the rate adjustment. The commissioner must respond to all applications within three weeks of receipt. The commissioner may waive the deadlines in this paragraph under extraordinary circumstances, to be determined at the sole discretion of the commissioner. The application must contain:

(1) an estimate of the amounts of money that must be used as specified in paragraph (b);

(2) a detailed distribution plan specifying the allowable compensation-related increases the nursing facility will implement to use the funds available in clause (1);

(3) a description of how the nursing facility will notify eligible employees of the contents of the approved application, which must provide for giving each eligible employee a copy of the approved application, excluding the information required in clause (1), or posting a copy of the approved application, excluding

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the information required in clause (1), for a period of at least six weeks in an area of the nursing facility to which all eligible employees have access; and

(4) instructions for employees who believe they have not received the compensation-related increases specified in clause (2), as approved by the commissioner, and which must include a mailing address, e-mail address, and the telephone number that may be used by the employee to contact the commissioner or the commissioner's representative.

(e) The commissioner shall ensure that cost increases in distribution plans under paragraph (d), clause (2), that may be included in approved applications, comply with the following requirements:

(1) a portion of the costs resulting from tenure-related wage or salary increases may be considered to be allowable wage increases, according to formulas that the commissioner shall provide, where employee retention is above the average statewide rate of retention of direct-care employees;

(2) the annualized amount of increases in costs for the employer's share of health and dental insurance, life insurance, disability insurance, and workers' compensation shall be allowable compensation-related increases if they are effective on or after April 1, 2013, and prior to April 1, 2014; and

(3) for nursing facilities in which employees are represented by an exclusive bargaining representative, the commissioner shall approve the application only upon receipt of a letter of acceptance of the distribution plan, in regard to members of the bargaining unit, signed by the exclusive bargaining agent, and dated after May 25, 2013. Upon receipt of the letter of acceptance, the commissioner shall deem all requirements of this provision as having been met in regard to the members of the bargaining unit.

(f) The commissioner shall review applications received under paragraph (d) and shall provide the portion of the rate adjustment under paragraph (b) if the requirements of this subdivision have been met. The rate adjustment shall be effective September 1, 2013. Notwithstanding paragraph (a), if the approved application distributes less money than is available, the amount of the rate adjustment shall be reduced so that the amount of money made available is equal to the amount to be distributed.

(g) The increase in this subdivision shall be applied as a percentage to operating payment rates in effect on August 31, 2013. For each facility, the commissioner shall determine the operating payment rate, not including any rate components resulting from equitable cost-sharing for publicly owned nursing facility program participation under section 256B.441, subdivision 55a, critical access nursing facility program participation under section 256B.441, subdivision 63, or performance-based incentive payment program participation under subdivision 4, paragraph (d), for a RUG class with a weight of 1.00 in effect on August 31, 2013.

Subd. 19b. **Nursing facility rate adjustments beginning October 1, 2015.** A total of a 3.2 percent average rate adjustment shall be provided as described under this subdivision and under section 256B.441, subdivision 46c.

(a) Beginning October 1, 2015, the commissioner shall make available to each nursing facility reimbursed under this section a 2.4 percent operating payment rate increase, in accordance with paragraphs (b) to (g).

(b) Seventy-five percent of the money resulting from the rate adjustment under paragraph (a) must be used for increases in compensation-related costs for employees directly employed by the nursing facility on or after the effective date of the rate adjustment, except:

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(1) the administrator;

(2) persons employed in the central office of a corporation that has an ownership interest in the nursing facility or exercises control over the nursing facility; and

(3) persons paid by the nursing facility under a management contract.

(c) The commissioner shall allow as compensation-related costs all costs for:

(1) wage and salary increases effective after May 25, 2015;

(2) the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, and workers' compensation;

(3) the employer's share of health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, and pensions; and

(4) other benefits provided and workforce needs, including the recruiting and training of employees, subject to the approval of the commissioner.

(d) The portion of the rate adjustment under paragraph (a) that is not subject to the requirements of paragraph (b) shall be provided to nursing facilities effective October 1, 2015. Nursing facilities may apply for the portion of the rate adjustment under paragraph (a) that is subject to the requirements in paragraph (b). The application must be submitted to the commissioner within six months of the effective date of the rate adjustment, and the nursing facility must provide additional information required by the commissioner within nine months of the effective date of the rate adjustment. The commissioner must respond to all applications within three weeks of receipt. The commissioner may waive the deadlines in this paragraph under extraordinary circumstances, to be determined at the sole discretion of the commissioner. The application must contain:

(1) an estimate of the amounts of money that must be used as specified in paragraph (b);

(2) a detailed distribution plan specifying the allowable compensation-related increases the nursing facility will implement to use the funds available in clause (1);

(3) a description of how the nursing facility will notify eligible employees of the contents of the approved application, which must provide for giving each eligible employee a copy of the approved application, excluding the information required in clause (1), or posting a copy of the approved application, excluding the information required in clause (1), for a period of at least six weeks in an area of the nursing facility to which all eligible employees have access; and

(4) instructions for employees who believe they have not received the compensation-related increases specified in clause (2), as approved by the commissioner, and which must include a mailing address, e-mail address, and the telephone number that may be used by the employee to contact the commissioner or the commissioner's representative.

(e) The commissioner shall ensure that cost increases in distribution plans under paragraph (d), clause (2), that may be included in approved applications, comply with the following requirements:

(1) a portion of the costs resulting from tenure-related wage or salary increases may be considered to be allowable wage increases, according to formulas that the commissioner shall provide, where employee retention is above the average statewide rate of retention of direct-care employees;

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(2) the annualized amount of increases in costs for the employer's share of health and dental insurance, life insurance, disability insurance, and workers' compensation shall be allowable compensation-related increases if they are effective on or after April 1, 2015, and prior to April 1, 2016; and

(3) for nursing facilities in which employees are represented by an exclusive bargaining representative, the commissioner shall approve the application only upon receipt of a letter of acceptance of the distribution plan, in regard to members of the bargaining unit, signed by the exclusive bargaining agent and dated after May 25, 2015.

Upon receipt of the letter of acceptance, the commissioner shall deem all requirements of this provision as having been met in regard to the members of the bargaining unit.

(f) The commissioner shall review applications received under paragraph (d) and shall provide the portion of the rate adjustment under paragraph (b) if the requirements of this subdivision have been met. The rate adjustment shall be effective October 1, 2015. Notwithstanding paragraph (a), if the approved application distributes less money than is available, the amount of the rate adjustment shall be reduced so that the amount of money made available is equal to the amount to be distributed.

(g) The increase in this subdivision shall be applied as a percentage to operating payment rates in effect on September 30, 2015. For each facility, the commissioner shall determine the operating payment rate, not including any rate components resulting from equitable cost-sharing for publicly owned nursing facility program participation under section 256B.441, subdivision 55a, critical access nursing facility program participation under section 256B.441, subdivision 63, or performance-based incentive payment program participation under subdivision 4, paragraph (d), for a RUG class with a weight of 1.00 in effect on September 30, 2015.

Subd. 20. **Payment of Public Employees Retirement Association costs.** Nursing facilities that participate in the Public Employees Retirement Association (PERA) shall have the component of their payment rate associated with the costs of PERA determined for each rate year. Effective for rate years beginning on and after October 1, 2007, the commissioner shall determine the portion of the payment rate in effect on September 30 each year and shall subtract that amount from the payment rate to be effective on the following October 1. The portion that shall be deemed to be included in the September 30, 2007, rate that is associated with PERA costs shall be the allowed costs in the facility's base for determining rates under this section, divided by the resident days reported for that year. The commissioner shall add to the payment rate to be effective on October 1 each year an amount equal to the reported costs associated with PERA, for the year ending on the most recent September 30 for which data is available, divided by total resident days for that year, as reported by the facility and audited under section 256B.441.

Subd. 21. **Payment of post-PERA pension benefit costs.** Nursing facilities that convert or converted after September 30, 2006, from public to private ownership shall have a portion of their post-PERA pension costs treated as a component of the historic operating rate. Effective for the rate years beginning on or after October 1, 2009, and prior to October 1, 2016, the commissioner shall determine the pension costs to be included in the facility's base for determining rates under this section by using the following formula: post-privatization pension benefit costs as a percentage of salary shall be determined from either the cost report for the first full reporting year after privatization or the most recent report year available, whichever is later. This percentage shall be applied to the salary costs of the alternative payment system base rate year to determine the allowable amount of pension costs. The adjustments provided for in sections 256B.431, 256B.434, and 256B.441, and any other law enacted after the base rate year and prior to the year for which rates are being determined shall be applied to the allowable amount. The adjusted allowable amount shall be

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added to the operating rate effective the first rate year PERA ceases to remain as a pass-through component of the rate.

History: *1995 c 207 art 7 s 32; 1996 c 451 art 5 s 28; 1997 c 187 art 4 s 8; 1997 c 203 art 3 s 10-12; art 9 s 11,12; 1998 c 407 art 3 s 13; 1999 c 245 art 3 s 21-24; 2000 c 449 s 13,14; 2000 c 488 art 9 s 22; 1Sp2001 c 9 art 5 s 23-26; 2002 c 277 s 32; 2002 c 370 art 1 s 113; 2003 c 55 s 4; 1Sp2003 c 14 art 2 s 36,37,57; 1Sp2005 c 4 art 7 s 40-42; 2006 c 282 art 20 s 21-24; 2007 c 147 art 7 s 21-23; 2009 c 79 art 8 s 58,59; 2009 c 101 art 2 s 109; 1Sp2011 c 9 art 7 s 28; 2012 c 247 art 4 s 31; 2013 c 108 art 7 s 24-26*

256B.435 [Repealed, 2012 c 216 art 9 s 38]

256B.436 [Repealed, 2012 c 216 art 9 s 38]

256B.437 NURSING FACILITY VOLUNTARY CLOSURE; ALTERNATIVES.

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to subdivisions 2 to 8.

(b) "Closure" means the cessation of operations of a nursing facility and delicensure and decertification of all beds within the facility.

(c) "Closure plan" means a plan to close a nursing facility and reallocate a portion of the resulting savings to provide planned closure rate adjustments at other facilities.

(d) "Commencement of closure" means the date on which residents and designated representatives are notified of a planned closure as provided in section 144A.161, subdivision 5a, as part of an approved closure plan.

(e) "Completion of closure" means the date on which the final resident of the nursing facility designated for closure in an approved closure plan is discharged from the facility.

(f) "Partial closure" means the delicensure and decertification of a portion of the beds within the facility.

(g) "Planned closure rate adjustment" means an increase in a nursing facility's operating rates resulting from a planned closure or a planned partial closure of another facility.

Subd. 2. [Repealed, 1Sp2003 c 14 art 2 s 57]

Subd. 3. **Applications for planned closure of nursing facilities.** (a) By August 15, 2001, the commissioner of human services shall implement and announce a program for closure or partial closure of nursing facilities. Names and identifying information provided in response to the announcement shall remain private unless approved, according to the timelines established in the plan. The announcement must specify:

(1) the criteria in subdivision 4 that will be used by the commissioner to approve or reject applications;

(2) the information that must accompany an application; and

(3) that applications may combine planned closure rate adjustments with moratorium exception funding, in which case a single application may serve both purposes.

Between August 1, 2001, and June 30, 2003, the commissioner may approve planned closures of up to 5,140 nursing facility beds, less the number of beds delicensed in facilities during the same time period without approved closure plans or that have notified the commissioner of health of their intent to close without an approved closure plan. Beginning July 1, 2004, the commissioner may negotiate a planned closure rate

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adjustment for nursing facilities providing the proposal, cumulatively, with other proposals that have been approved, has no cost to the state. For planned closure rate adjustments negotiated after March 1, 2006, the limit of $2,080 in subdivision 6, paragraph (a), clause (1), shall not apply. The removal of the limit in subdivision 6, paragraph (a), clause (1), shall not constitute an increase to the amount specified in subdivision 6, paragraph (a), clause (1), for the purposes of subdivision 6, paragraph (f).

(b) A facility or facilities reimbursed under section 256B.431 or 256B.434 with a closure plan approved by the commissioner under subdivision 5 may assign a planned closure rate adjustment to another facility or facilities that are not closing or in the case of a partial closure, to the facility undertaking the partial closure. A facility may also elect to have a planned closure rate adjustment shared equally by the five nursing facilities with the lowest total operating payment rates in the state development region designated under section 462.385, in which the facility that is closing is located. The planned closure rate adjustment must be calculated under subdivision 6. Facilities that delicense beds without a closure plan, or whose closure plan is not approved by the commissioner, are not eligible to assign a planned closure rate adjustment under subdivision 6, unless they are delicensing five or fewer beds, or less than six percent of their total licensed bed capacity, whichever is greater, are located in a county in the top three quartiles of beds per 1,000 persons aged 65 or older, and have not delicensed beds in the prior three months. Facilities meeting these criteria are eligible to assign the amount calculated under subdivision 6 to themselves. If a facility is delicensing the greater of six or more beds, or six percent or more of its total licensed bed capacity, and does not have an approved closure plan or is not eligible for the adjustment under subdivision 6, the commissioner shall calculate the amount the facility would have been eligible to assign under subdivision 6, and shall use this amount to provide equal rate adjustments to the five nursing facilities with the lowest total operating payment rates in the state development region designated under section 462.385, in which the facility that delicensed beds is located.

(c) To be considered for approval, an application must include:

(1) a description of the proposed closure plan, which must include identification of the facility or facilities to receive a planned closure rate adjustment;

(2) the proposed timetable for any proposed closure, including the proposed dates for announcement to residents, commencement of closure, and completion of closure;

(3) if available, the proposed relocation plan for current residents of any facility designated for closure. If a relocation plan is not available, the application must include a statement agreeing to develop a relocation plan designed to comply with section 144A.161;

(4) a description of the relationship between the nursing facility that is proposed for closure and the nursing facility or facilities proposed to receive the planned closure rate adjustment. If these facilities are not under common ownership, copies of any contracts, purchase agreements, or other documents establishing a relationship or proposed relationship must be provided;

(5) documentation, in a format approved by the commissioner, that all the nursing facilities receiving a planned closure rate adjustment under the plan have accepted joint and several liability for recovery of overpayments under section 256B.0641, subdivision 2, for the facilities designated for closure under the plan; and

(6) an explanation of how the application coordinates with planning efforts under subdivision 2. If the planning group does not support a level of nursing facility closures that the commissioner considers to be reasonable, the commissioner may approve a planned closure proposal without its support.

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(d) The application must address the criteria listed in subdivision 4.

Subd. 4. **Criteria for review of application.** In reviewing and approving closure proposals, the commissioner shall consider, but not be limited to, the following criteria:

(1) improved quality of care and quality of life for consumers;

(2) closure of a nursing facility that has a poor physical plant;

(3) the existence of excess nursing facility beds, measured in terms of beds per thousand persons aged 85 or older. The excess must be measured in reference to:

(i) the county in which the facility is located;

(ii) the county and all contiguous counties;

(iii) the region in which the facility is located; or

(iv) the facility's service area;

the facility shall indicate in its application the service area it believes is appropriate for this measurement. A facility in a county that is in the lowest quartile of counties with reference to beds per thousand persons aged 85 or older is not in an area of excess capacity;

(4) low-occupancy rates, provided that the unoccupied beds are not the result of a personnel shortage. In analyzing occupancy rates, the commissioner shall examine waiting lists in the applicant facility and at facilities in the surrounding area, as determined under clause (3);

(5) evidence of coordination between the community planning process and the facility application. If the planning group does not support a level of nursing facility closures that the commissioner considers to be reasonable, the commissioner may approve a planned closure proposal without its support;

(6) proposed usage of funds available from a planned closure rate adjustment for care-related purposes;

(7) innovative use planned for the closed facility's physical plant;

(8) evidence that the proposal serves the interests of the state; and

(9) evidence of other factors that affect the viability of the facility, including excessive nursing pool costs.

Subd. 5. **Review and approval of applications.** (a) The commissioner of human services, in consultation with the commissioner of health, shall approve or disapprove an application within 30 days after receiving it. The commissioner may appoint an advisory review panel composed of representatives of counties, SAIL projects, consumers, and providers to review proposals and provide comments and recommendations to the committee. The commissioners of human services and health shall provide staff and technical assistance to the committee for the review and analysis of proposals.

(b) Approval of a planned closure expires 18 months after approval by the commissioner of human services, unless commencement of closure has begun.

(c) The commissioner of human services may change any provision of the application to which the applicant, the regional planning group, and the commissioner agree.

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Subd. 6. **Planned closure rate adjustment.** (a) The commissioner of human services shall calculate the amount of the planned closure rate adjustment available under subdivision 3, paragraph (b), for up to 5,140 beds according to clauses (1) to (4):

(1) the amount available is the net reduction of nursing facility beds multiplied by $2,080;

(2) the total number of beds in the nursing facility or facilities receiving the planned closure rate adjustment must be identified;

(3) capacity days are determined by multiplying the number determined under clause (2) by 365; and

(4) the planned closure rate adjustment is the amount available in clause (1), divided by capacity days determined under clause (3).

(b) A planned closure rate adjustment under this section is effective on the first day of the month following completion of closure of the facility designated for closure in the application and becomes part of the nursing facility's external fixed payment rate.

(c) Upon the request of a closing facility, the commissioner must allow the facility a closure rate adjustment as provided under section 144A.161, subdivision 10.

(d) A facility that has received a planned closure rate adjustment may reassign it to another facility that is under the same ownership at any time within three years of its effective date. The amount of the adjustment shall be computed according to paragraph (a).

(e) If the per bed dollar amount specified in paragraph (a), clause (1), is increased, the commissioner shall recalculate planned closure rate adjustments for facilities that delicense beds under this section on or after July 1, 2001, to reflect the increase in the per bed dollar amount. The recalculated planned closure rate adjustment shall be effective from the date the per bed dollar amount is increased.

(f) For planned closures approved after June 30, 2009, the commissioner of human services shall calculate the amount of the planned closure rate adjustment available under subdivision 3, paragraph (b), according to paragraph (a), clauses (1) to (4).

(g) Between July 16, 2011, and June 30, 2013, the commissioner shall not accept applications for planned closure rate adjustments under subdivision 3.

Subd. 7. **Other rate adjustments.** Facilities receiving planned closure rate adjustments remain eligible for any applicable rate adjustments provided under section 256B.431, 256B.434, or any other section.

Subd. 8. [Repealed, 2013 c 63 s 20]

Subd. 9. **Transfer of beds.** The board of commissioners of St. Louis County may amend their planned closure rate adjustment application to allow up to 50 beds of a 159-licensed bed county-owned nursing facility that is in the process of closing to be transferred to a hospital-attached nursing facility in Aurora and up to 50 beds to a 235-bed nursing facility in Duluth, and may also assign all or a portion of the planned closure rate adjustment that would be received as a result of closure to the Aurora facility or the Duluth facility.

Subd. 10. **Big Stone County rate adjustment.** Notwithstanding the requirements of this section, the commissioner shall approve a planned closure rate adjustment in Big Stone County for an eight-bed facility

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in Clinton for reassignment to a 50-bed facility in Graceville. The adjustment shall be calculated according to subdivisions 3 and 6.

History: *1Sp2001 c 9 art 5 s 27; 2002 c 220 art 14 s 11; 2002 c 362 s 5; 2002 c 375 art 2 s 39,40; 2002 c 379 art 1 s 113; 2004 c 194 s 2; 2006 c 282 art 20 s 25; 2007 c 147 art 7 s 24; 2009 c 79 art 8 s 60; 2011 c 22 art 2 s 3; 1Sp2011 c 9 art 7 s 29; 2013 c 108 art 7 s 27*

256B.438 IMPLEMENTATION OF A CASE MIX SYSTEM.

Subdivision 1. **Scope.** This section establishes the method and criteria used to determine resident reimbursement classifications based upon the assessments of residents of nursing homes and boarding care homes whose payment rates are established under section 256B.431, 256B.434, or 256B.441 or any other section. Resident reimbursement classifications shall be established according to the 34 group, resource utilization groups, version III or RUG-III model as described in section 144.0724. Reimbursement classifications established under this section shall be implemented after June 30, 2002, but no later than January 1, 2003. Reimbursement classifications established under this section shall be implemented no earlier than six weeks after the commissioner mails notices of payment rates to the facilities. Effective January 1, 2012, resident reimbursement classifications shall be established according to the 48 group, resource utilization groups, RUG-IV model under section 144.0724.

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

(a) "Assessment reference date" has the meaning given in section 144.0724, subdivision 2, paragraph (a).

(b) "Case mix index" has the meaning given in section 144.0724, subdivision 2, paragraph (b).

(c) "Index maximization" has the meaning given in section 144.0724, subdivision 2, paragraph (c).

(d) "Minimum data set" has the meaning given in section 144.0724, subdivision 2, paragraph (d).

(e) "Representative" has the meaning given in section 144.0724, subdivision 2, paragraph (e).

(f) "Resource utilization groups" or "RUG" has the meaning given in section 144.0724, subdivision 2, paragraph (f).

Subd. 3. **Case mix indices.** (a) The commissioner of human services shall assign a case mix index to each resident class based on the Centers for Medicare and Medicaid Services staff time measurement study and adjusted for Minnesota-specific wage indices. The case mix indices assigned to each resident class shall be published in the Minnesota State Register at least 120 days prior to the implementation of the 34 group, RUG-III resident classification system.

(b) An index maximization approach shall be used to classify residents.

(c) After implementation of the revised case mix system, the commissioner of human services may annually rebase case mix indices and base rates using more current data on average wage rates and staff time measurement studies. This rebasing shall be calculated under subdivision 7, paragraph (b). The commissioner shall publish in the Minnesota State Register adjusted case mix indices at least 45 days prior to the effective date of the adjusted case mix indices.

(d) Upon implementation of the 48-group RUG-IV resident classification system, the commissioner of human services shall assign a case mix index to each resident class based on the Centers for Medicare and

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Medicaid Services staff time measurement study. The case mix indices assigned to each resident class shall be published in the State Register at least 120 days prior to the implementation of the RUG-IV resident classification system.

Subd. 4. **Resident assessment schedule.** (a) Nursing facilities shall conduct and submit case mix assessments according to the schedule established by the commissioner of health under section 144.0724, subdivisions 4 and 5.

(b) The resident reimbursement classifications established under section 144.0724, subdivision 3, shall be effective the day of admission for new admission assessments. The effective date for significant change assessments shall be the assessment reference date. The effective date for annual and quarterly assessments shall be the first day of the month following assessment reference date.

(c) Effective October 1, 2006, the commissioner shall rebase payment rates to account for the change in the resident assessment schedule in section 144.0724, subdivision 4, paragraph (b), clause (4), in a facility specific budget neutral manner, according to subdivision 7, paragraph (b).

(d) Effective January 1, 2012, the commissioner shall determine payment rates to account for the transition to RUG-IV, in a facility-specific, revenue-neutral manner, according to subdivision 8, paragraph (b).

Subd. 5. **Notice of resident reimbursement classification.** Nursing facilities shall provide notice to a resident of the resident's case mix classification according to procedures established by the commissioner of health under section 144.0724, subdivision 7.

Subd. 6. **Reconsideration of resident classification.** Any request for reconsideration of a resident classification must be made under section 144.0724, subdivision 8.

Subd. 7. **Rate determination upon transition to RUG-III payment rates.** (a) The commissioner of human services shall determine payment rates at the time of transition to the RUG based payment model in a facility-specific, budget-neutral manner. The case mix indices as defined in subdivision 3 shall be used to allocate the case mix adjusted component of total payment across all case mix groups. To transition from the current calculation methodology to the RUG based methodology, the commissioner of health shall report to the commissioner of human services the resident days classified according to the categories defined in subdivision 3 for the 12-month reporting period ending September 30, 2001, for each nursing facility. The commissioner of human services shall use this data to compute the standardized days for the reporting period under the RUG system.

(b) The commissioner of human services shall determine the case mix adjusted component of the rate as follows:

(1) determine the case mix portion of the 11 case mix rates in effect on June 30, 2002, or the 34 case mix rates in effect on or after June 30, 2003;

(2) multiply each amount in clause (1) by the number of resident days assigned to each group for the reporting period ending September 30, 2001, or the most recent year for which data is available;

(3) compute the sum of the amounts in clause (2);

(4) determine the total RUG standardized days for the reporting period ending September 30, 2001, or the most recent year for which data is available using the new indices calculated under subdivision 3, paragraph (c);

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(5) divide the amount in clause (3) by the amount in clause (4) which shall be the average case mix adjusted component of the rate under the RUG method; and

(6) multiply this average rate by the case mix weight in subdivision 3 for each RUG group.

(c) The noncase mix component will be allocated to each RUG group as a constant amount to determine the transition payment rate. Any other rate adjustments that are effective on or after July 1, 2002, shall be applied to the transition rates determined under this section.

Subd. 8. **Rate determination upon transition to RUG-IV payment rates.** (a) The commissioner of human services shall determine payment rates at the time of transition to the RUG-IV-based payment model in a facility-specific, revenue-neutral manner. To transition from the current calculation methodology to the RUG-IV-based methodology, nursing facilities shall report to the commissioner of human services the private pay and Medicaid resident days classified according to the categories defined in subdivision 3, paragraphs (a) and (d), for the six-month reporting period ending June 30, 2011. This report must be submitted to the commissioner, in a form prescribed by the commissioner, by August 15, 2011. The commissioner of human services shall use this data to compute the standardized days for the RUG-III and RUG-IV classification systems.

(b) The commissioner of human services shall determine the case mix adjusted component for the January 1, 2012, rate as follows:

(1) using the September 30, 2010, cost report, determine the case mix portion of the operating cost for each facility;

(2) multiply the 36 operating payment rates in effect on December 31, 2011, by the number of private pay and Medicaid resident days assigned to each group for the reporting period ending June 30, 2011, and compute the total;

(3) compute the product of the amounts in clauses (1) and (2);

(4) determine the private pay and Medicaid RUG standardized days for the reporting period ending June 30, 2011, using the new indices calculated under subdivision 3, paragraph (d);

(5) divide the amount determined in clause (3) by the amount in clause (4), which shall be the default rate (DDF) unadjusted case mix component of the rate under the RUG-IV method; and

(6) determine the case mix adjusted component of each operating rate by multiplying the default rate (DDF) unadjusted case mix component by the case mix weight in subdivision 3, paragraph (d), for each RUG-IV group.

(c) The noncase mix components will be allocated to each RUG group as a constant amount to determine the operating payment rate.

History: *1Sp2001 c 9 art 5 s 28; 2002 c 277 s 32; 2002 c 375 art 2 s 41; 2002 c 379 art 1 s 113; 2006 c 282 art 20 s 26; 1Sp2011 c 9 art 7 s 30-33*

256B.439 LONG-TERM CARE QUALITY PROFILES.

Subdivision 1. **Development and implementation of quality profiles.** (a) The commissioner of human services, in cooperation with the commissioner of health, shall develop and implement quality profiles for nursing facilities and, beginning not later than July 1, 2014, for home and community-based services providers, except when the quality profile system would duplicate requirements under section 256B.5011,

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256B.5012, or 256B.5013. For purposes of this section, home and community-based services providers are defined as providers of home and community-based services under sections 256B.0625, subdivisions 6a, 7, and 19a; 256B.0913; 256B.0915; 256B.092; 256B.49; and 256B.85, and intermediate care facilities for persons with developmental disabilities providers under section 256B.5013. To the extent possible, quality profiles must be developed for providers of services to older adults and people with disabilities, regardless of payor source, for the purposes of providing information to consumers. The quality profiles must be developed using existing data sets maintained by the commissioners of health and human services to the extent possible. The profiles must incorporate or be coordinated with information on quality maintained by area agencies on aging, long-term care trade associations, the ombudsman offices, counties, tribes, health plans, and other entities and the long-term care database maintained under section 256.975, subdivision 7. The profiles must be designed to provide information on quality to:

(1) consumers and their families to facilitate informed choices of service providers;

(2) providers to enable them to measure the results of their quality improvement efforts and compare quality achievements with other service providers; and

(3) public and private purchasers of long-term care services to enable them to purchase high-quality care.

(b) The profiles must be developed in consultation with the long-term care task force, area agencies on aging, and representatives of consumers, providers, and labor unions. Within the limits of available appropriations, the commissioners may employ consultants to assist with this project.

Subd. 2. **Quality measurement tools for nursing facilities.** The commissioners shall identify and apply existing quality measurement tools to:

(1) emphasize quality of care and its relationship to quality of life; and

(2) address the needs of various users of long-term care services, including, but not limited to, short-stay residents, persons with behavioral problems, persons with dementia, and persons who are members of minority groups.

The tools must be identified and applied, to the extent possible, without requiring providers to supply information beyond state and federal requirements.

Subd. 2a. **Quality measurement tools for home and community-based services.** (a) The commissioners shall identify and apply quality measurement tools to:

(1) emphasize service quality and its relationship to quality of life; and

(2) address the needs of various users of home and community-based services.

(b) The tools must include, but not be limited to, surveys of consumers of home and community-based services. The tools must be identified and applied, to the extent possible, without requiring providers to supply information beyond state and federal requirements, for purposes of this subdivision.

Subd. 3. **Consumer surveys of nursing facilities residents.** Following identification of the quality measurement tool, the commissioners shall conduct surveys of long-term care service consumers of nursing facilities to develop quality profiles of providers. To the extent possible, surveys must be conducted face-to-face by state employees or contractors. At the discretion of the commissioners, surveys may be conducted by telephone or by provider staff. Surveys must be conducted periodically to update quality profiles of individual nursing facilities providers.

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Subd. 3a. **Consumer surveys for home and community-based services.** Following identification of the quality measurement tool, and within the limits of the appropriation, the commissioner shall conduct surveys of home and community-based services consumers to develop quality profiles of providers. To the extent possible, surveys must be conducted face-to-face by state employees or contractors. At the discretion of the commissioner, surveys may be conducted by an alternative method. Surveys must be conducted periodically to update quality profiles of individual service providers.

Subd. 3b. **Home and community-based services report card in cooperation with the commissioner of health.** The commissioner shall work with existing Department of Human Services advisory groups to develop recommendations for a home and community-based services report card. Health and human services staff that regulate home and community-based services as provided in chapter 245D and licensed home care as provided in chapter 144A shall be consulted. The advisory groups shall consider the requirements from the Minnesota consumer information guide under section 144G.06 as a base for development of the home and community-based services report card to compare the housing options available to consumers. Other items to be considered by the advisory groups in developing recommendations include:

(1) defining the goals of the report card, including measuring outcomes, providing consumer information, and defining vehicle-for-pay performance;

(2) developing separate measures for programs for the elderly population and for persons with disabilities;

(3) the sources of information needed that are standardized and contain sufficient data;

(4) the financial support needed for creating and publicizing the housing information guide, and ongoing funding for data collection and staffing to monitor, report, and analyze;

(5) a recognition that home and community-based services settings exist with significant variations in size, settings, and services available;

(6) ensuring that consumer choice and consumer information are retained and valued;

(7) the applicability of these measures to providers based on payor source, size, and population served; and

(8) dissemination of quality profiles.

The advisory groups shall discuss whether there are additional funding, resources, and research needed. The commissioner shall report recommendations to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services issues by August 1, 2014. The report card shall be available on July 1, 2015.

Subd. 4. **Dissemination of quality profiles.** By July 1, 2014, the commissioners shall implement a public awareness effort to disseminate the quality profiles. Profiles may be disseminated through the Senior LinkAge Line and Disability Linkage Line and to consumers, providers, and purchasers of long-term care services.

Subd. 5. **Implementation of home and community-based services performance-based incentive payment program.** By April 1, 2014, the commissioner shall develop incentive-based grants for home and community-based services providers for achieving outcomes specified in a contract. The commissioner may solicit proposals from home and community-based services providers and implement those that, on a

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competitive basis, best meet the state's policy objectives. The commissioner shall determine the types of home and community-based services providers that will participate in the program. The determination of participating provider types may be revised annually by the commissioner. The commissioner shall limit the amount of any incentive-based grants and the number of grants under this subdivision to operate the incentive payments within funds appropriated for this purpose. The grant agreements may specify various levels of payment for various levels of performance. In establishing the specified outcomes and related criteria, the commissioner shall consider the following state policy objectives:

(1) provide more efficient, higher quality services;

(2) encourage home and community-based services providers to innovate;

(3) equip home and community-based services providers with organizational tools and expertise to improve their quality;

(4) incentivize home and community-based services providers to invest in better services; and

(5) disseminate successful performance improvement strategies statewide.

Subd. 6. **Calculation of home and community-based services quality score.** (a) The commissioner shall determine a quality score for each participating home and community-based services provider using quality measures established in subdivisions 1 and 2a, according to methods determined by the commissioner in consultation with stakeholders and experts. These methods shall be exempt from the rulemaking requirements under chapter 14.

(b) For each quality measure, a score shall be determined with a maximum number of points available and number of points assigned as determined by the commissioner using the methodology established according to this subdivision. The determination of the quality measures to be used and the methods of calculating scores may be revised annually by the commissioner.

Subd. 7. **Calculation of home and community-based services quality add-on.** On July 1, 2015, the commissioner shall determine the quality add-on rate change and adjust payment rates for all home and community-based services providers for services rendered on or after that date. The adjustment to a provider payment rate determined under this subdivision shall become part of the ongoing rate paid to that provider. The payment rate for the quality add-on shall be a variable amount based on each provider's quality score as determined in subdivisions 1 and 2a. All home and community-based services providers shall receive a minimum rate increase under this subdivision. In addition to a minimum rate increase, a home and community-based services provider shall receive a quality add-on payment. The commissioner shall limit the types of home and community-based services providers that may receive the quality add-on based on availability of quality measures and outcome data. The commissioner shall limit the amount of the minimum rate increase and quality add-on payments to the equivalent of a one percent rate increase for all home and community-based services providers.

History: *1Sp2001 c 9 art 5 s 29; 2002 c 220 art 14 s 12,13; 2002 c 379 art 1 s 113; 2013 c 108 art 2 s 32-34,44; art 7 s 28-34; art 15 s 3,4; 2014 c 312 art 27 s 56,57*

256B.44 Subdivision 1. [Repealed, 1983 c 199 s 19]

Subd. 2. [Repealed, 1979 c 336 s 18; 1983 c 199 s 19]

Subd. 3. [Repealed, 1983 c 199 s 19]

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256B.440 [Repealed, 2014 c 262 art 4 s 9]

256B.441 VALUE-BASED NURSING FACILITY REIMBURSEMENT SYSTEM.

Subdivision 1. **Rebasing of nursing facility operating payment rates.** (a) The commissioner shall rebase nursing facility operating payment rates to align payments to facilities with the cost of providing care. The rebased operating payment rates shall be calculated using the statistical and cost report filed by each nursing facility for the report period ending one year prior to the rate year.

(b) The new operating payment rates based on this section shall take effect beginning with the rate year beginning October 1, 2008, and shall be phased in over eight rate years through October 1, 2015. For each year of the phase-in, the operating payment rates shall be calculated using the statistical and cost report filed by each nursing facility for the report period ending one year prior to the rate year.

(c) Operating payment rates shall be rebased on October 1, 2016, and every two years after that date.

(d) Each cost reporting year shall begin on October 1 and end on the following September 30. Beginning in 2014, a statistical and cost report shall be filed by each nursing facility by February 1. Notice of rates shall be distributed by August 15 and the rates shall go into effect on October 1 for one year.

(e) Effective October 1, 2014, property rates shall be rebased in accordance with section 256B.431 and Minnesota Rules, chapter 9549. The commissioner shall determine what the property payment rate for a nursing facility would be had the facility not had its property rate determined under section 256B.434. The commissioner shall allow nursing facilities to provide information affecting this rate determination that would have been filed annually under Minnesota Rules, chapter 9549, and nursing facilities shall report information necessary to determine allowable debt. The commissioner shall use this information to determine the property payment rate.

Subd. 2. **Definitions.** For purposes of this section, the terms in subdivisions 3 to 42a have the meanings given unless otherwise provided for in this section.

Subd. 3. **Active beds.** "Active beds" means licensed beds that are not currently in layaway status.

Subd. 4. **Activities costs.** "Activities costs" means the costs for the salaries and wages of the supervisor and other activities workers, associated fringe benefits and payroll taxes, supplies, services, and consultants.

Subd. 5. **Administrative costs.** "Administrative costs" means the direct costs for administering the overall activities of the nursing home. These costs include salaries and wages of the administrator, assistant administrator, business office employees, security guards, and associated fringe benefits and payroll taxes, fees, contracts, or purchases related to business office functions, licenses, and permits except as provided in the external fixed costs category, employee recognition, travel including meals and lodging, all training except as specified in subdivision 11, voice and data communication or transmission, office supplies, liability insurance and other forms of insurance not designated to other areas, personnel recruitment, legal services, accounting services, management or business consultants, data processing, information technology, Web site, central or home office costs, business meetings and seminars, postage, fees for professional organizations, subscriptions, security services, advertising, board of director's fees, working capital interest expense, and bad debts and bad debt collection fees.

Subd. 6. **Allowed costs.** "Allowed costs" means the amounts reported by the facility which are necessary for the operation of the facility and the care of residents and which are reviewed by the department for

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accuracy; reasonableness, in accordance with the requirements set forth in title XVIII of the federal Social Security Act and the interpretations in the provider reimbursement manual; and compliance with this section and generally accepted accounting principles. All references to costs in this section shall be assumed to refer to allowed costs.

Subd. 7. **Center for Medicare and Medicaid services.** "Center for Medicare and Medicaid services" means the federal agency, in the United States Department of Health and Human Services that administers Medicaid, also referred to as "CMS."

Subd. 8. **Commissioner.** "Commissioner" means the commissioner of human services unless specified otherwise.

Subd. 9. **Desk audit.** "Desk audit" means the establishment of the payment rate based on the commissioner's review and analysis of required reports, supporting documentation, and work sheets submitted by the nursing facility.

Subd. 10. **Dietary costs.** "Dietary costs" means the costs for the salaries and wages of the dietary supervisor, dietitians, chefs, cooks, dishwashers, and other employees assigned to the kitchen and dining room, and associated fringe benefits and payroll taxes. Dietary costs also includes the salaries or fees of dietary consultants, dietary supplies, and food preparation and serving.

Subd. 11. **Direct care costs.** "Direct care costs" means costs for the wages of nursing administration, direct care registered nurses, licensed practical nurses, certified nursing assistants, trained medication aides, employees conducting training in resident care topics and associated fringe benefits and payroll taxes; services from a supplemental nursing services agency; supplies that are stocked at nursing stations or on the floor and distributed or used individually, including, but not limited to: alcohol, applicators, cotton balls, incontinence pads, disposable ice bags, dressings, bandages, water pitchers, tongue depressors, disposable gloves, enemas, enema equipment, soap, medication cups, diapers, plastic waste bags, sanitary products, thermometers, hypodermic needles and syringes, clinical reagents or similar diagnostic agents, drugs that are not paid on a separate fee schedule by the medical assistance program or any other payer, and technology related to the provision of nursing care to residents, such as electronic charting systems; costs of materials used for resident care training, and training courses outside of the facility attended by direct care staff on resident care topics.

Subd. 12. [Repealed, 2007 c 147 art 7 s 76]

Subd. 13. **External fixed costs.** "External fixed costs" means costs related to the nursing home surcharge under section 256.9657, subdivision 1; licensure fees under section 144.122; until September 30, 2013, long-term care consultation fees under section 256B.0911, subdivision 6; family advisory council fee under section 144A.33; scholarships under section 256B.431, subdivision 36; planned closure rate adjustments under section 256B.437; or single bed room incentives under section 256B.431, subdivision 42; property taxes and property insurance; and PERA.

Subd. 14. **Facility average case mix index.** "Facility average case mix index" or "CMI" means a numerical value score that describes the relative resource use for all residents within the groups under the resource utilization group (RUG-III) classification system prescribed by the commissioner based on an assessment of each resident. The facility average CMI shall be computed as the standardized days divided by total days for all residents in the facility. The RUG's weights used in this section shall be as follows for each RUG's class: SE3 1.605; SE2 1.247; SE1 1.081; RAD 1.509; RAC 1.259; RAB 1.109; RAA 0.957; SSC 1.453; SSB 1.224; SSA 1.047; CC2 1.292; CC1 1.200; CB2 1.086; CB1 1.017; CA2 0.908; CA1 0.834;

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IB2 0.877; IB1 0.817; IA2 0.720; IA1 0.676; BB2 0.956; BB1 0.885; BA2 0.716; BA1 0.673; PE2 1.199; PE1 1.104; PD2 1.023; PD1 0.948; PC2 0.926; PC1 0.860; PB2 0.786; PB1 0.734; PA2 0.691; PA1 0.651; BC1 0.651; and DDF 1.000.

Subd. 14a. **Facility type groups.** Facilities shall be classified into two groups, called "facility type groups," which shall consist of:

(1) C&NC/R80: facilities that are hospital-attached, or are licensed under Minnesota Rules, parts 9570.2000 to 9570.3400; and

(2) freestanding: all other facilities.

Subd. 15. **Field audit.** "Field audit" means the examination, verification, and review of the financial records, statistical records, and related supporting documentation on the nursing home and any related organization.

Subd. 16. [Repealed, 2007 c 147 art 7 s 76]

Subd. 17. **Fringe benefit costs.** "Fringe benefit costs" means the costs for group life, health, dental, workers' compensation, and other employee insurances and pension, profit sharing, and retirement plans for which the employer pays all or a portion of the costs.

Subd. 18. **Generally accepted accounting principles.** "Generally Accepted Accounting Principles" means the body of pronouncements adopted by the American Institute of Certified Public Accountants regarding proper accounting procedures, guidelines, and rules.

Subd. 19. **Hospital-attached nursing facility status.** (a) For the purpose of setting rates under this section, for rate years beginning after September 30, 2006, "hospital-attached nursing facility" means a nursing facility which meets the requirements of clauses (1) and (2); or (3); or (4), or had hospital-attached status prior to January 1, 1995, and has been recognized as having hospital-attached status by CMS continuously since that date:

(1) the nursing facility is recognized by the federal Medicare program to be a hospital-based nursing facility;

(2) the hospital and nursing facility are physically attached or connected by a corridor;

(3) a nursing facility and hospital, which have applied for hospital-based nursing facility status under the federal Medicare program during the reporting year, shall be considered a hospital-attached nursing facility for purposes of setting payment rates under this section. The nursing facility must file its cost report for that reporting year using Medicare principles and Medicare's recommended cost allocation methods had the Medicare program's hospital-based nursing facility status been granted to the nursing facility. For each subsequent rate year, the nursing facility must meet the definition requirements in clauses (1) and (2). If the nursing facility is denied hospital-based nursing facility status under the Medicare program, the nursing facility's payment rates for the rate years the nursing facility was considered to be a hospital-attached nursing facility according to this paragraph shall be recalculated treating the nursing facility as a non-hospital-attached nursing facility;

(4) if a nonprofit or community-operated hospital and attached nursing facility suspend operation of the hospital, the remaining nursing facility must be allowed to continue its status as hospital-attached for rate calculations in the three rate years subsequent to the one in which the hospital ceased operations.

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(b) The nursing facility's cost report filed as hospital-attached facility shall use the same cost allocation principles and methods used in the reports filed for the Medicare program. Direct identification of costs to the nursing facility cost center will be permitted only when the comparable hospital costs have also been directly identified to a cost center which is not allocated to the nursing facility.

Subd. 20. **Housekeeping costs.** "Housekeeping costs" means the costs for the salaries and wages of the housekeeping supervisor, housekeepers, and other cleaning employees and associated fringe benefits and payroll taxes. It also includes the cost of housekeeping supplies, including, but not limited to, cleaning and lavatory supplies and contract services.

Subd. 21. [Repealed, 2007 c 147 art 7 s 76]

Subd. 22. **Laundry costs.** "Laundry costs" means the costs for the salaries and wages of the laundry supervisor and other laundry employees, associated fringe benefits, and payroll taxes. It also includes the costs of linen and bedding, the laundering of resident clothing, laundry supplies, and contract services.

Subd. 23. **Licensee.** "Licensee" means the individual or organization listed on the form issued by the Minnesota Department of Health under chapter 144A or sections 144.50 to 144.56.

Subd. 24. **Maintenance and plant operations costs.** "Maintenance and plant operations costs" means the costs for the salaries and wages of the maintenance supervisor, engineers, heating-plant employees, and other maintenance employees and associated fringe benefits and payroll taxes. It also includes direct costs for maintenance and operation of the building and grounds, including, but not limited to, fuel, electricity, medical waste and garbage removal, water, sewer, supplies, tools, and repairs.

Subd. 25. **Normalized direct care costs per day.** "Normalized direct care costs per day" means direct care costs divided by standardized days. It is the costs per day for direct care services associated with a RUG's index of 1.00.

Subd. 26. [Repealed, 2007 c 147 art 7 s 76]

Subd. 27. **Nursing facility.** "Nursing facility" means a facility with a medical assistance provider agreement that is licensed as a nursing home under chapter 144A or as a boarding care home under sections 144.50 to 144.56.

Subd. 28. [Repealed, 2007 c 147 art 7 s 76]

Subd. 28a. **Other direct care costs.** "Other direct care costs" means the costs for the salaries and wages and associated fringe benefits and payroll taxes of mental health workers, religious personnel, and other direct care employees not specified in the definition of direct care costs.

Subd. 29. **Payroll taxes.** "Payroll taxes" means the costs for the employer's share of the FICA and Medicare withholding tax, and state and federal unemployment compensation taxes.

Subd. 30. **Peer groups.** Facilities shall be classified into three groups by county. The groups shall consist of:

(1) group one: facilities in Anoka, Benton, Carlton, Carver, Chisago, Dakota, Dodge, Goodhue, Hennepin, Isanti, Mille Lacs, Morrison, Olmsted, Ramsey, Rice, Scott, Sherburne, St. Louis, Stearns, Steele, Wabasha, Washington, Winona, or Wright County;

(2) group two: facilities in Aitkin, Beltrami, Blue Earth, Brown, Cass, Clay, Cook, Crow Wing, Faribault, Fillmore, Freeborn, Houston, Hubbard, Itasca, Kanabec, Koochiching, Lake, Lake of the Woods,

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Le Sueur, Martin, McLeod, Meeker, Mower, Nicollet, Norman, Pine, Roseau, Sibley, Todd, Wadena, Waseca, Watonwan, or Wilkin County; and

(3) group three: facilities in all other counties.

Subd. 31. **Prior system operating cost payment rate.** "Prior system operating cost payment rate" means the operating cost payment rate in effect on September 30, 2008, under Minnesota Rules and Minnesota Statutes, not including planned closure rate adjustments under section 256B.437 or single bed room incentives under section 256B.431, subdivision 42.

Subd. 32. **Private paying resident.** "Private paying resident" means a nursing facility resident who is not a medical assistance recipient and whose payment rate is not established by another third party, including the veterans administration or Medicare.

Subd. 33. **Rate year.** "Rate year" means the 12-month period beginning on October 1 following the second most recent reporting year.

Subd. 33a. **Raw food costs.** "Raw food costs" means the cost of food provided to nursing facility residents. Also included are special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet.

Subd. 34. **Related organization.** "Related organization" means a person that furnishes goods or services to a nursing facility and that is a close relative of a nursing facility, an affiliate of a nursing facility, a close relative of an affiliate of a nursing facility, or an affiliate of a close relative of an affiliate of a nursing facility. As used in this subdivision, paragraphs (a) to (d) apply.

(a) "Affiliate" means a person that directly, or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with another person.

(b) "Person" means an individual, a corporation, a partnership, an association, a trust, an unincorporated organization, or a government or political subdivision.

(c) "Close relative of an affiliate of a nursing facility" means an individual whose relationship by blood, marriage, or adoption to an individual who is an affiliate of a nursing facility is no more remote than first cousin.

(d) "Control" including the terms "controlling," "controlled by," and "under common control with" means the possession, direct or indirect, of the power to direct or cause the direction of the management, operations, or policies of a person, whether through the ownership of voting securities, by contract, or otherwise.

Subd. 35. **Reporting period.** "Reporting period" means the one-year period beginning on October 1 and ending on the following September 30 during which incurred costs are accumulated and then reported on the statistical and cost report.

Subd. 36. **Resident day or actual resident day.** "Resident day" or "actual resident day" means a day for which nursing services are rendered and billable, or a day for which a bed is held and billed. The day of admission is considered a resident day, regardless of the time of admission. The day of discharge is not considered a resident day, regardless of the time of discharge.

Subd. 37. **Salaries and wages.** "Salaries and wages" means amounts earned by and paid to employees or on behalf of employees to compensate for necessary services provided. Salaries and wages include accrued

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vested vacation and accrued vested sick leave pay. Salaries and wages must be paid within 30 days of the end of the reporting period in order to be allowable costs of the reporting period.

Subd. 38. **Social services costs.** "Social services costs" means the costs for the salaries and wages of the supervisor and other social work employees, associated fringe benefits and payroll taxes, supplies, services, and consultants. This category includes the cost of those employees who manage and process admission to the nursing facility.

Subd. 39. **Stakeholders.** "Stakeholders" means individuals and representatives of organizations interested in long-term care, including nursing homes, consumers, and labor unions.

Subd. 40. **Standardized days.** "Standardized days" means the sum of resident days by case mix category multiplied by the RUG index for each category.

Subd. 41. **Statistical and cost report.** "Statistical and cost report" means the forms supplied by the commissioner for annual reporting of nursing facility expenses and statistics, including instructions and definitions of items in the report.

Subd. 42. [Repealed, 2007 c 147 art 7 s 76]

Subd. 42a. **Therapy costs.** "Therapy costs" means any costs related to medical assistance therapy services provided to residents that are not billed separately from the daily operating rate.

Subd. 43. **Reporting of statistical and cost information.** (a) Beginning in 2006, all nursing facilities shall provide information annually to the commissioner on a form and in a manner determined by the commissioner. The commissioner may also require nursing facilities to provide statistical and cost information for a subset of the items in the annual report on a semiannual basis. Nursing facilities shall report only costs directly related to the operation of the nursing facility. The facility shall not include costs which are separately reimbursed by residents, medical assistance, or other payors. Allocations of costs from central, affiliated, or corporate office and related organization transactions shall be reported according to section 256B.432. Beginning with the September 30, 2013, reporting year, the commissioner shall no longer grant to facilities extensions to the filing deadline. The commissioner may separately require facilities to submit in a manner specified by the commissioner documentation of statistical and cost information included in the report to ensure accuracy in establishing payment rates and to perform audit and appeal review functions under this section. Facilities shall retain all records necessary to document statistical and cost information on the report for a period of no less than seven years. The commissioner may amend information in the report according to subdivision 47. The commissioner may reject a report filed by a nursing facility under this section if the commissioner determines that the report has been filed in a form that is incomplete or inaccurate and the information is insufficient to establish accurate payment rates. In the event that a complete report is not submitted in a timely manner, the commissioner shall reduce the reimbursement payments to a nursing facility to 85 percent of amounts due until the information is filed. The release of withheld payments shall be retroactive for no more than 90 days. A nursing facility that does not submit a report or whose report is filed in a timely manner but determined to be incomplete shall be given written notice that a payment reduction is to be implemented and allowed ten days to complete the report prior to any payment reduction. The commissioner may delay the payment withhold under exceptional circumstances to be determined at the sole discretion of the commissioner.

(b) Nursing facilities may, within 12 months of the due date of a statistical and cost report, file an amendment when errors or omissions in the annual statistical and cost report are discovered and an

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amendment would result in a rate increase of at least 0.15 percent of the statewide weighted average operating payment rate and shall, at any time, file an amendment which would result in a rate reduction of at least 0.15 percent of the statewide weighted average operating payment rate. The commissioner shall make retroactive adjustments to the total payment rate of a nursing facility if an amendment is accepted. Where a retroactive adjustment is to be made as a result of an amended report, audit findings, or other determination of an incorrect payment rate, the commissioner may settle the payment error through a negotiated agreement with the facility and a gross adjustment of the payments to the facility. Retroactive adjustments shall not be applied to private pay residents. An error or omission for purposes of this item does not include a nursing facility's determination that an election between permissible alternatives was not advantageous and should be changed.

(c) If the commissioner determines that a nursing facility knowingly supplied inaccurate or false information or failed to file an amendment to a statistical and cost report that resulted in or would result in an overpayment, the commissioner shall immediately adjust the nursing facility's payment rate and recover the entire overpayment. The commissioner may also terminate the commissioner's agreement with the nursing facility and prosecute under applicable state or federal law.

Subd. 44. **Calculation of a quality score.** (a) The commissioner shall determine a quality score for each nursing facility using quality measures established in section 256B.439, according to methods determined by the commissioner in consultation with stakeholders and experts. These methods shall be exempt from the rulemaking requirements under chapter 14.

(b) For each quality measure, a score shall be determined with a maximum number of points available and number of points assigned as determined by the commissioner using the methodology established according to this subdivision. The scores determined for all quality measures shall be totaled. The determination of the quality measures to be used and the methods of calculating scores may be revised annually by the commissioner.

(c) For the initial rate year under the new payment system, the quality measures shall include:

(1) staff turnover;

(2) staff retention;

(3) use of pool staff;

(4) quality indicators from the minimum data set; and

(5) survey deficiencies.

(d) Beginning July 1, 2013, the quality score shall be a value between zero and 100, using data as provided in the Minnesota nursing home report card, with 50 percent derived from the Minnesota quality indicators score, 40 percent derived from the resident quality of life score, and ten percent derived from the state inspection results score.

(e) The commissioner, in cooperation with the commissioner of health, may adjust the formula in paragraph (d), or the methodology for computing the total quality score, effective July 1 of any year beginning in 2014, with five months advance public notice. In changing the formula, the commissioner shall consider quality measure priorities registered by report card users, advice of stakeholders, and available research.

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Subd. 45. [Repealed, 2007 c 147 art 7 s 76]

Subd. 46. [Repealed, 2014 c 262 art 4 s 9]

Subd. 46a. [Repealed, 2014 c 262 art 4 s 9]

Subd. 46b. **Calculation of quality add-on, with an average value of 1.25 percent, effective September 1, 2013.** (a) The commissioner shall determine quality add-ons to the operating payment rates for each facility. The increase in this subdivision shall be applied as a percentage to operating payment rates in effect on August 31, 2013. For each facility, the commissioner shall determine the operating payment rate, not including any rate components resulting from equitable cost-sharing for publicly owned nursing facility program participation under subdivision 55a, critical access nursing facility program participation under subdivision 63, or performance-based incentive payment program participation under section 256B.434, subdivision 4, paragraph (d), for a RUG class with a weight of 1.00 in effect on August 31, 2013.

(b) For each facility, the commissioner shall compute a quality factor by subtracting 40 from the most recent quality score computed under subdivision 44, and then dividing by 60. If the quality factor is less than zero, the commissioner shall use the value zero.

(c) The quality add-ons shall be the operating payment rates determined in paragraph (a), multiplied by the quality factor determined in paragraph (b), and then multiplied by 3.2 percent. The commissioner shall implement the quality add-ons effective September 1, 2013.

Subd. 46c. **Quality improvement incentive system beginning October 1, 2015.** The commissioner shall develop a quality improvement incentive program in consultation with stakeholders. The annual funding pool available for quality improvement incentive payments shall be equal to 0.8 percent of all operating payments, not including any rate components resulting from equitable cost-sharing for publicly owned nursing facility program participation under subdivision 55a, critical access nursing facility program participation under subdivision 63, or performance-based incentive payment program participation under section 256B.434, subdivision 4, paragraph (d). Beginning October 1, 2015, annual rate adjustments provided under this subdivision shall be effective for one year, starting October 1 and ending the following September 30.

Subd. 47. **Audit authority.** (a) The commissioner may subject reports and supporting documentation to desk and field audits to determine compliance with this section. Retroactive adjustments shall be made as a result of desk or field audit findings if the cumulative impact of the finding would result in a rate adjustment of at least 0.15 percent of the statewide weighted average operating payment rate. If a field audit reveals inadequacies in a nursing facility's record keeping or accounting practices, the commissioner may require the nursing facility to engage competent professional assistance to correct those inadequacies within 90 days so that the field audit may proceed.

(b) Field audits may cover the four most recent annual statistical and cost reports for which desk audits have been completed and payment rates have been established. The field audit must be an independent review of the nursing facility's statistical and cost report. All transactions, invoices, or other documentation that support or relate to the statistics and costs claimed on the annual statistical and cost reports are subject to review by the field auditor. If the provider fails to provide the field auditor access to supporting documentation related to the information reported on the statistical and cost report within the time period specified by the commissioner, the commissioner shall calculate the total payment rate by disallowing the cost of the items for which access to the supporting documentation is not provided.

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(c) Changes in the total payment rate which result from desk or field audit adjustments to statistical and cost reports for reporting years earlier than the four most recent annual cost reports must be made to the four most recent annual statistical and cost reports, the current statistical and cost report, and future statistical and cost reports to the extent that those adjustments affect the total payment rate established by those reporting years.

(d) The commissioner shall extend the period for retention of records under subdivision 43 for purposes of performing field audits as necessary to enforce section 256B.48 with written notice to the facility postmarked no later than 90 days prior to the expiration of the record retention requirement.

Subd. 48. **Calculation of operating per diems.** The direct care per diem for each facility shall be the facility's direct care costs divided by its standardized days. The other care-related per diem shall be the sum of the facility's activities costs, other direct care costs, raw food costs, therapy costs, and social services costs, divided by the facility's resident days. The other operating per diem shall be the sum of the facility's administrative costs, dietary costs, housekeeping costs, laundry costs, and maintenance and plant operations costs divided by the facility's resident days.

Subd. 49. **Determination of total care-related per diem.** The total care-related per diem for each facility shall be the sum of the direct care per diem and the other care-related per diem.

Subd. 50. **Determination of total care-related limit.** (a) The limit on the total care-related per diem shall be determined for each peer group and facility type group combination. A facility's total care-related per diems shall be limited to 120 percent of the median for the facility's peer and facility type group. The facility-specific direct care costs used in making this comparison and in the calculation of the median shall be based on a RUG's weight of 1.00. A facility that is above that limit shall have its total care-related per diem reduced to the limit. If a reduction of the total care-related per diem is necessary because of this limit, the reduction shall be made proportionally to both the direct care per diem and the other care-related per diem.

(b) Beginning with rates determined for October 1, 2016, the total care-related limit shall be a variable amount based on each facility's quality score, as determined under subdivision 44, in accordance with clauses (1) to (4):

(1) for each facility, the commissioner shall determine the quality score, subtract 40, divide by 40, and convert to a percentage;

(2) if the value determined in clause (1) is less than zero, the total care-related limit shall be 105 percent of the median for the facility's peer and facility type group;

(3) if the value determined in clause (1) is greater than 100 percent, the total care-related limit shall be 125 percent of the median for the facility's peer and facility type group; and

(4) if the value determined in clause (1) is greater than zero and less than 100 percent, the total care-related limit shall be 105 percent of the median for the facility's peer and facility type group plus one-fifth of the percentage determined in clause (1).

Subd. 50a. **Determination of proximity adjustments.** (a) For a nursing facility located in close proximity to another nursing facility of the same facility group type but in a different peer group and that has higher limits for care-related or other operating costs, the commissioner shall adjust the limits in accordance with clauses (1) to (4):

(1) determine the difference between the limits;

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(2) determine the distance between the two facilities, by the shortest driving route. If the distance exceeds 20 miles, no adjustment shall be made;

(3) subtract the value in clause (2) from 20 miles, divide by 20, and convert to a percentage; and

(4) increase the limits for the nursing facility with the lower limits by the value determined in clause (1) multiplied by the value determined in clause (3).

(b) Effective October 1, 2011, nursing facilities located no more than one-quarter mile from a peer group with higher limits under either subdivision 50 or 51, may receive an operating rate adjustment. The operating payment rates of a lower-limit peer group facility must be adjusted to be equal to those of the nearest facility in a higher-limit peer group if that facility's RUG rate with a weight of 1.00 is higher than the lower-limit peer group facility. Peer groups are those defined in subdivision 30. The nearest facility must be determined by the most direct driving route.

Subd. 51. **Determination of other operating limit.** The limit on the other operating per diem shall be determined for each peer group. A facility's other operating per diem shall be limited to 105 percent of the median for its peer group. A facility that is above that limit shall have its other operating per diem reduced to the limit.

Subd. 51a. **Exception allowing contracting for specialized care.** (a) For rate years beginning on or after October 1, 2016, the commissioner may negotiate increases to the care-related limit for nursing facilities that provide specialized care, at a cost to the general fund not to exceed $600,000 per year. The commissioner shall publish a request for proposals annually, and may negotiate increases to the limits that shall apply for either one or two years before the increase shall be subject to a new proposal and negotiation. The care-related limit may be increased by up to 50 percent.

(b) In selecting facilities with which to negotiate, the commissioner shall consider:

(1) the diagnoses or other circumstances of residents in the specialized program that require care that costs substantially more than the RUG's rates associated with those residents;

(2) the nature of the specialized program or programs offered to meet the needs of these individuals; and

(3) outcomes achieved by the specialized program.

Subd. 52. **Determination of efficiency incentive.** Each facility shall be eligible for an efficiency incentive based on its other operating per diem. A facility with an other operating per diem that exceeds the limit in subdivision 51 shall receive no efficiency incentive. All other facilities shall receive an incentive calculated as 50 percent times the difference between the facility's other operating per diem and its other operating per diem limit, up to a maximum incentive of $3.

Subd. 53. **Calculation of payment rate for external fixed costs.** The commissioner shall calculate a payment rate for external fixed costs.

(a) For a facility licensed as a nursing home, the portion related to section 256.9657 shall be equal to $8.86. For a facility licensed as both a nursing home and a boarding care home, the portion related to section 256.9657 shall be equal to $8.86 multiplied by the result of its number of nursing home beds divided by its total number of licensed beds.

(b) The portion related to the licensure fee under section 144.122, paragraph (d), shall be the amount of the fee divided by actual resident days.

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(c) The portion related to scholarships shall be determined under section 256B.431, subdivision 36.

(d) Until September 30, 2013, the portion related to long-term care consultation shall be determined according to section 256B.0911, subdivision 6.

(e) The portion related to development and education of resident and family advisory councils under section 144A.33 shall be $5 divided by 365.

(f) The portion related to planned closure rate adjustments shall be as determined under section 256B.437, subdivision 6, and Minnesota Statutes 2010, section 256B.436. Planned closure rate adjustments that take effect before October 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning October 1, 2016. Planned closure rate adjustments that take effect on or after October 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning on October 1 of the first year not less than two years after their effective date.

(g) The portions related to property insurance, real estate taxes, special assessments, and payments made in lieu of real estate taxes directly identified or allocated to the nursing facility shall be the actual amounts divided by actual resident days.

(h) The portion related to the Public Employees Retirement Association shall be actual costs divided by resident days.

(i) The single bed room incentives shall be as determined under section 256B.431, subdivision 42. Single bed room incentives that take effect before October 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning October 1, 2016. Single bed room incentives that take effect on or after October 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning on October 1 of the first year not less than two years after their effective date.

(j) The payment rate for external fixed costs shall be the sum of the amounts in paragraphs (a) to (i).

Subd. 54. **Determination of total payment rates.** In rate years when rates are rebased, the total payment rate for a RUG's weight of 1.00 shall be the sum of the total care-related payment rate, other operating payment rate, efficiency incentive, external fixed cost rate, and the property rate determined under section 256B.434. To determine a total payment rate for each RUG's level, the total care-related payment rate shall be divided into the direct care payment rate and the other care-related payment rate, and the direct care payment rate multiplied by the RUG's weight for each RUG's level using the weights in subdivision 14.

Subd. 55. **Phase-in of rebased operating payment rates.** (a) For the rate years beginning October 1, 2008, to October 1, 2015, the operating payment rate calculated under this section shall be phased in by blending the operating rate with the operating payment rate determined under section 256B.434. For purposes of this subdivision, the rate to be used that is determined under section 256B.434 shall not include the portion of the operating payment rate related to performance-based incentive payments under section 256B.434, subdivision 4, paragraph (d). For the rate year beginning October 1, 2008, the operating payment rate for each facility shall be 13 percent of the operating payment rate from this section, and 87 percent of the operating payment rate from section 256B.434. For the rate period from October 1, 2009, to September 30, 2013, no rate adjustments shall be implemented under this section, but shall be determined under section 256B.434. For the rate year beginning October 1, 2013, the operating payment rate for each facility shall be 65 percent of the operating payment rate from this section, and 35 percent of the operating payment rate from section 256B.434. For the rate year beginning October 1, 2014, the operating payment rate for each facility shall be 82 percent of the operating payment rate from this section, and 18 percent of the operating

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payment rate from section 256B.434. For the rate year beginning October 1, 2015, the operating payment rate for each facility shall be the operating payment rate determined under this section. The blending of operating payment rates under this section shall be performed separately for each RUG's class.

(b) For the rate year beginning October 1, 2008, the commissioner shall apply limits to the operating payment rate increases under paragraph (a) by creating a minimum percentage increase and a maximum percentage increase.

(1) Each nursing facility that receives a blended October 1, 2008, operating payment rate increase under paragraph (a) of less than one percent, when compared to its operating payment rate on September 30, 2008, computed using rates with RUG's weight of 1.00, shall receive a rate adjustment of one percent.

(2) The commissioner shall determine a maximum percentage increase that will result in savings equal to the cost of allowing the minimum increase in clause (1). Nursing facilities with a blended October 1, 2008, operating payment rate increase under paragraph (a) greater than the maximum percentage increase determined by the commissioner, when compared to its operating payment rate on September 30, 2008, computed using rates with a RUG's weight of 1.00, shall receive the maximum percentage increase.

(3) Nursing facilities with a blended October 1, 2008, operating payment rate increase under paragraph (a) greater than one percent and less than the maximum percentage increase determined by the commissioner, when compared to its operating payment rate on September 30, 2008, computed using rates with a RUG's weight of 1.00, shall receive the blended October 1, 2008, operating payment rate increase determined under paragraph (a).

(4) The October 1, 2009, through October 1, 2015, operating payment rate for facilities receiving the maximum percentage increase determined in clause (2) shall be the amount determined under paragraph (a) less the difference between the amount determined under paragraph (a) for October 1, 2008, and the amount allowed under clause (2). This rate restriction does not apply to rate increases provided in any other section.

(c) A portion of the funds received under this subdivision that are in excess of operating payment rates that a facility would have received under section 256B.434, as determined in accordance with clauses (1) to (3), shall be subject to the requirements in section 256B.434, subdivision 19, paragraphs (b) to (h).

(1) Determine the amount of additional funding available to a facility, which shall be equal to total medical assistance resident days from the most recent reporting year times the difference between the blended rate determined in paragraph (a) for the rate year being computed and the blended rate for the prior year.

(2) Determine the portion of all operating costs, for the most recent reporting year, that are compensation related. If this value exceeds 75 percent, use 75 percent.

(3) Subtract the amount determined in clause (2) from 75 percent.

(4) The portion of the fund received under this subdivision that shall be subject to the requirements in section 256B.434, subdivision 19, paragraphs (b) to (h), shall equal the amount determined in clause (1) times the amount determined in clause (3).

Subd. 55a. **Alternative to phase-in for publicly owned nursing facilities.** (a) For operating payment rates implemented between October 1, 2011, and the day before the phase-in under subdivision 55 is complete, the commissioner shall allow nursing facilities whose physical plant is owned or whose license is held by a city, county, or hospital district to apply for a higher payment rate under this section if the local

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governmental entity agrees to pay a specified portion of the nonfederal share of medical assistance costs. Nursing facilities that apply shall be eligible to select an operating payment rate, with a weight of 1.00, up to the rate calculated in subdivision 54, without application of the phase-in under subdivision 55. The rates for the other RUGs shall be computed as provided under subdivision 54.

(b) For operating payment rates implemented beginning the day when the phase-in under subdivision 55 is complete, the commissioner shall allow nursing facilities whose physical plant is owned or whose license is held by a city, county, or hospital district to apply for a higher payment rate under this section if the local governmental entity agrees to pay a specified portion of the nonfederal share of medical assistance costs. Nursing facilities that apply are eligible to select an operating payment rate with a weight of 1.00, up to an amount determined by the commissioner to be allowable under the Medicare upper payment limit test. The rates for the other RUGs shall be computed under subdivision 54. The rate increase allowed in this paragraph shall take effect only upon federal approval.

(c) Rates determined under this subdivision shall take effect beginning October 1, 2011, based on cost reports for the reporting year ending September 30, 2010, and in future rate years, rates determined for nursing facilities participating under this subdivision shall take effect on October 1 of each year, based on the most recent available cost report.

(d) Eligible nursing facilities that wish to participate under this subdivision shall make an application to the commissioner by August 31, 2011, or by June 30 of any subsequent year.

(e) For each participating nursing facility, the public entity that owns the physical plant or is the license holder of the nursing facility shall pay to the state the entire nonfederal share of medical assistance payments received as a result of the difference between the nursing facility's payment rate under paragraph (a) or (b), and the rates that the nursing facility would otherwise be paid without application of this subdivision under subdivision 54 or 55 as determined by the commissioner.

(f) The commissioner may, at any time, reduce the payments under this subdivision based on the commissioner's determination that the payments shall cause nursing facility rates to exceed the state's Medicare upper payment limit or any other federal limitation. If the commissioner determines a reduction is necessary, the commissioner shall reduce all payment rates for participating nursing facilities by a percentage applied to the amount of increase they would otherwise receive under this subdivision and shall notify participating facilities of the reductions. If payments to a nursing facility are reduced, payments under section 256B.19, subdivision 1e, shall be reduced accordingly.

Subd. 56. **Hold harmless.** For the rate years beginning October 1, 2008, to October 1, 2016, no nursing facility shall receive an operating cost payment rate less than its operating cost payment rate under section 256B.434. For rate years beginning between October 1, 2009, and October 1, 2015, no nursing facility shall receive an operating payment rate less than its operating payment rate in effect on September 30, 2009. The comparison of operating payment rates under this section shall be made for a RUG's rate with a weight of 1.00.

Subd. 57. **Appeals.** Nursing facilities may appeal, as described under section 256B.50, the determination of a payment rate established under this chapter.

Subd. 58. **Implementation delay.** Within six months prior to the effective date of (1) rebasing of property payment rates under subdivision 1; (2) quality-based rate limits under subdivision 50; and (3) the removal of planned closure rate adjustments and single bed room incentives from external fixed costs under subdivision 53, the commissioner shall compare the average operating cost for all facilities combined

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from the most recent cost reports to the average medical assistance operating payment rates for all facilities combined from the same time period. Each provision shall not go into effect until the average medical assistance operating payment rate is at least 92 percent of the average operating cost. The rebasing of property payment rates under subdivision 1, and the removal of planned closure rate adjustments and single-bed room incentives from external fixed costs under subdivision 53 shall not go into effect until 82 percent of the operating payment rate from this section is phased in as described in subdivision 55.

Subd. 59. **Single-bed payments for medical assistance recipients.** Effective October 1, 2009, the amount paid for a private room under Minnesota Rules, part 9549.0070, subpart 3, is reduced from 115 percent to 111.5 percent.

Subd. 60. **Method for determining budget-neutral nursing facility rates for relocated beds.** (a) Nursing facility rates for bed relocations must be calculated by comparing the estimated medical assistance costs prior to and after the proposed bed relocation using the calculations in this subdivision. All payment rates are based on a 1.0 case mix level, with other case mix rates determined accordingly. Nursing facility beds on layaway status that are being moved must be included in the calculation for both the originating and receiving facility and treated as though they were in active status with the occupancy characteristics of the active beds of the originating facility.

(b) Medical assistance costs of the beds in the originating nursing facilities must be calculated as follows:

(1) multiply each originating facility's total payment rate for a RUGS weight of 1.0 by the facility's percentage of medical assistance days on its most recent available cost report;

(2) take the products in clause (1) and multiply by each facility's average case mix score for medical assistance residents on its most recent available cost report;

(3) take the products in clause (2) and multiply by the number of beds being relocated, times 365; and

(4) calculate the sum of the amounts determined in clause (3).

(c) Medical assistance costs in the receiving facility, prior to the bed relocation, must be calculated as follows:

(1) multiply the facility's total payment rate for a RUGS weight of 1.0 by the medical assistance days on the most recent cost report; and

(2) multiply the product in clause (1) by the average case mix weight of medical assistance residents on the most recent cost report.

(d) The commissioner shall determine the medical assistance costs prior to the bed relocation which must be the sum of the amounts determined in paragraphs (b) and (c).

(e) The commissioner shall estimate the medical assistance costs after the bed relocation as follows:

(1) estimate the medical assistance days in the receiving facility after the bed relocation. The commissioner may use the current medical assistance portion, or if data does not exist, may use the statewide average, or may use the provider's estimate of the medical assistance utilization of the relocated beds;

(2) estimate the average case mix weight of medical assistance residents in the receiving facility after the bed relocation. The commissioner may use current average case mix weight or, if data does not exist, may use the statewide average, or may use the provider's estimate of the average case mix weight; and

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(3) multiply the amount determined in clause (1) by the amount determined in clause (2) by the total payment rate for a RUGS weight of 1.0 that is the highest rate of the facilities from which the relocated beds either originate or to which they are being relocated so long as that rate is associated with ten percent or more of the total number of beds to be in the receiving facility after the bed relocation.

(f) If the amount determined in paragraph (e) is less than or equal to the amount determined in paragraph (d), the commissioner shall allow a total payment rate equal to the amount used in paragraph (e), clause (3).

(g) If the amount determined in paragraph (e) is greater than the amount determined in paragraph (d), the commissioner shall allow a rate with a RUGS weight of 1.0 that when used in paragraph (e), clause (3), results in the amount determined in paragraph (e) being equal to the amount determined in paragraph (d).

(h) If the commissioner relies upon provider estimates in paragraph (e), clause (1) or (2), then annually, for three years after the rates determined in this subdivision take effect, the commissioner shall determine the accuracy of the alternative factors of medical assistance case load and RUGS weight used in this subdivision and shall reduce the total payment rate for a RUGS weight of 1.0 if the factors used result in medical assistance costs exceeding the amount in paragraph (d). If the actual medical assistance costs exceed the estimates by more than five percent, the commissioner shall also recover the difference between the estimated costs in paragraph (e) and the actual costs according to section 256B.0641. The commissioner may require submission of data from the receiving facility needed to implement this paragraph.

(i) When beds approved for relocation are put into active service at the destination facility, rates determined in this subdivision must be adjusted by any adjustment amounts that were implemented after the date of the letter of approval.

Subd. 61. **Rate increase for low-rate facilities.** Effective October 1, 2011, operating payment rates of all nursing facilities that are reimbursed under this section or section 256B.434 shall be increased for a resource utilization group rate with a weight of 1.00 by up to 2.45 percent, but not to exceed for the same resource utilization group weight the rate of the facility at the 18th percentile of all nursing facilities in the state. The percentage of the operating payment rate for each facility to be case-mix adjusted shall be equal to the percentage that is case-mix adjusted in that facility's operating payment rate on the preceding September 30.

Subd. 62. **Repeal of rebased operating payment rates.** Notwithstanding subdivision 54 or 55, no further steps toward phase-in of rebased operating payment rates shall be taken.

Subd. 63. **Critical access nursing facilities.** (a) The commissioner, in consultation with the commissioner of health, may designate certain nursing facilities as critical access nursing facilities. The designation shall be granted on a competitive basis, within the limits of funds appropriated for this purpose.

(b) The commissioner shall request proposals from nursing facilities every two years. Proposals must be submitted in the form and according to the timelines established by the commissioner. In selecting applicants to designate, the commissioner, in consultation with the commissioner of health, and with input from stakeholders, shall develop criteria designed to preserve access to nursing facility services in isolated areas, rebalance long-term care, and improve quality. Beginning in fiscal year 2015, to the extent practicable, the commissioner shall ensure an even distribution of designations across the state.

(c) The commissioner shall allow the benefits in clauses (1) to (5) for nursing facilities designated as critical access nursing facilities:

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(1) partial rebasing, with the commissioner allowing a designated facility operating payment rates being the sum of up to 60 percent of the operating payment rate determined in accordance with subdivision 54 and at least 40 percent, with the sum of the two portions being equal to 100 percent, of the operating payment rate that would have been allowed had the facility not been designated. The commissioner may adjust these percentages by up to 20 percent and may approve a request for less than the amount allowed;

(2) enhanced payments for leave days. Notwithstanding section 256B.431, subdivision 2r, upon designation as a critical access nursing facility, the commissioner shall limit payment for leave days to 60 percent of that nursing facility's total payment rate for the involved resident, and shall allow this payment only when the occupancy of the nursing facility, inclusive of bed hold days, is equal to or greater than 90 percent;

(3) two designated critical access nursing facilities, with up to 100 beds in active service, may jointly apply to the commissioner of health for a waiver of Minnesota Rules, part 4658.0500, subpart 2, in order to jointly employ a director of nursing. The commissioner of health will consider each waiver request independently based on the criteria under Minnesota Rules, part 4658.0040;

(4) the minimum threshold under section 256B.431, subdivision 15, paragraph (e), shall be 40 percent of the amount that would otherwise apply; and

(5) notwithstanding subdivision 58, beginning October 1, 2014, the quality-based rate limits under subdivision 50 shall apply to designated critical access nursing facilities.

(d) Designation of a critical access nursing facility shall be for a period of two years, after which the benefits allowed under paragraph (c) shall be removed. Designated facilities may apply for continued designation.

Subd. 64. **Rate adjustments for compensation-related costs.** (a) Operating payment rates of all nursing facilities that are reimbursed under this section or section 256B.434 shall be increased effective for rate years beginning on and after October 1, 2014, to address changes in compensation costs for nursing facility employees paid less than $14 per hour in accordance with this subdivision.

(b) Based on the application in paragraph (d), the commissioner shall calculate the allowable annualized compensation costs by adding the totals of clauses (1), (2), and (3). The result must be divided by the standardized or resident days from the most recently available cost report to determine per diem amounts, which must be included in the operating portion of the total payment rate and allocated to direct care or other operating as determined by the commissioner:

(1) the sum of the difference between $8 and any hourly wage rate less than $8 for October 1, 2014; between $9 and any hourly wage rate less than $9 for October 1, 2015; between $9.50 and any hourly wage rate less than $9.50 for October 1, 2016; and between the indexed value of the minimum wage, as defined in section 177.24, subdivision 1, paragraph (f), and any hourly wage less than that indexed value for rate years beginning on and after October 1, 2017; multiplied by the number of compensated hours at that wage rate;

(2) using wages and hours in effect during the first three months of calendar year 2014, beginning with the first pay period beginning on or after January 1, 2014; 33.3 percent of the sum of items (i) to (viii) for October 1, 2014; 44.4 percent of the sum of items (i) to (viii) for October 1, 2015; and 22.2 percent of the sum of items (i) to (viii) for October 1, 2016;

(i) for all compensated hours from $8 to $8.49 per hour, the number of compensated hours is multiplied by $0.13;

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(ii) for all compensated hours from $8.50 to $8.99 per hour, the number of compensated hours is multiplied by $0.25;

(iii) for all compensated hours from $9 to $9.49 per hour, the number of compensated hours is multiplied by $0.38;

(iv) for all compensated hours from $9.50 to $10.49 per hour, the number of compensated hours is multiplied by $0.50;

(v) for all compensated hours from $10.50 to $10.99 per hour, the number of compensated hours is multiplied by $0.40;

(vi) for all compensated hours from $11 to $11.49 per hour, the number of compensated hours is multiplied by $0.30;

(vii) for all compensated hours from $11.50 to $11.99 per hour, the number of compensated hours is multiplied by $0.20; and

(viii) for all compensated hours from $12 to $13 per hour, the number of compensated hours is multiplied by $0.10; and

(3) the sum of the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, pensions, and contributions to employee retirement accounts attributable to the amounts in clauses (1) and (2).

(c) For the rate years beginning October 1, 2014, and later, nursing facilities that receive approval of the applications in paragraph (d) must receive rate adjustments according to paragraph (b). The rate adjustments must be used to pay compensation costs for nursing facility employees paid less than $14 per hour.

(d) To receive a rate adjustment, nursing facilities must submit applications to the commissioner in a form and manner determined by the commissioner. The applications for the rate adjustments shall include specified data, and spending plans that describe how the funds from the rate adjustments will be allocated for compensation to employees paid less than $14 per hour. The applications must be submitted within three months of the effective date of any operating payment rate adjustment under this subdivision. The commissioner may request any additional information needed to determine the rate adjustment within three weeks of receiving a complete application. The nursing facility must provide any additional information requested by the commissioner within six months of the effective date of any operating payment rate adjustment under this subdivision. The commissioner may waive the deadlines in this subdivision under extraordinary circumstances.

(e) For nursing facilities in which employees are represented by an exclusive bargaining representative, the commissioner shall approve the applications submitted under this subdivision only upon receipt of a letter or letters of acceptance of the spending plans in regard to members of the bargaining unit, signed by the exclusive bargaining agent and dated after May 31, 2014. Upon receipt of the letter or letters of acceptance, the commissioner shall deem all requirements of this subdivision as having been met in regard to the members of the bargaining unit.

History: *1Sp2005 c 4 art 7 s 43; 2006 c 212 art 3 s 21; 2007 c 147 art 7 s 25-57; 2008 c 363 art 15 s 10-12; 2009 c 79 art 8 s 61-63; 2009 c 159 s 98,99; 2009 c 173 art 1 s 29; 2010 c 396 s 5; 1Sp2010 c 1 art 15 s 8; art 17 s 12; 2011 c 22 art 1 s 7; 2011 c 76 art 1 s 80; 1Sp2011 c 9 art 7 s 34-37; 2012 c 216*

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art 9 s 26-28; 2012 c 247 art 4 s 32; 2013 c 63 s 12-14; 2013 c 108 art 2 s 35,36,44; art 7 s 35-37; art 15 s 3,4; 2014 c 312 art 27 s 58,59

256B.45 [Repealed, 1983 c 199 s 19]

256B.46 [Repealed, 1983 c 199 s 19]

256B.47 NONALLOWABLE COSTS; NOTICE OF INCREASES.

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.

Subd. 2. **Notice to residents.** (a) No increase in nursing facility rates for private paying residents shall be effective unless the nursing facility notifies the resident or person responsible for payment of the increase in writing 30 days before the increase takes effect.

A nursing facility may adjust its rates without giving the notice required by this subdivision when the purpose of the rate adjustment is to reflect a change in the case-mix classification of the resident. If the state fails to set rates as required by section 256B.431, subdivision 1, the time required for giving notice is decreased by the number of days by which the state was late in setting the rates.

(b) If the state does not set rates by the date required in section 256B.431, subdivision 1, nursing facilities shall meet the requirement for advance notice by informing the resident or person responsible for payments, on or before the effective date of the increase, that a rate increase will be effective on that date. If the exact amount has not yet been determined, the nursing facility may raise the rates by the amount anticipated to be allowed. Any amounts collected from private pay residents in excess of the allowable rate must be repaid to private pay residents with interest at the rate used by the commissioner of revenue for the late payment of taxes and in effect on the date the rate increase is effective.

Subd. 3. **Allocation of costs.** To ensure the avoidance of double payments as required by section 256B.433, the direct and indirect reporting year costs of providing residents of nursing facilities that are not hospital attached with therapy services that are billed separately from the nursing facility payment rate or according to Minnesota Rules, parts 9500.0750 to 9500.1080, must be determined and deducted from the appropriate cost categories of the annual cost report as follows:

(a) The costs of wages and salaries for employees providing or participating in providing and consultants providing services shall be allocated to the therapy service based on direct identification.

(b) The costs of fringe benefits and payroll taxes relating to the costs in paragraph (a) must be allocated to the therapy service based on direct identification or the ratio of total costs in paragraph (a) to the sum of total allowable salaries and the costs in paragraph (a).

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(c) The costs of housekeeping, plant operations and maintenance, real estate taxes, special assessments, and insurance, other than the amounts classified as a fringe benefit, must be allocated to the therapy service based on the ratio of service area square footage to total facility square footage.

(d) The costs of bookkeeping and medical records must be allocated to the therapy service either by the method in paragraph (e) or based on direct identification. Direct identification may be used if adequate documentation is provided to, and accepted by, the commissioner.

(e) The costs of administrators, bookkeeping, and medical records salaries, except as provided in paragraph (d), must be allocated to the therapy service based on the ratio of the total costs in paragraphs (a) to (d) to the sum of total allowable nursing facility costs and the costs in paragraphs (a) to (d).

(f) The cost of property must be allocated to the therapy service and removed from the nursing facility's property-related payment rate, based on the ratio of service area square footage to total facility square footage multiplied by the property-related payment rate.

Subd. 4. **Allocation of costs; hospital-attached facilities.** To ensure the avoidance of double payments as required by section 256B.433, the direct and indirect reporting year costs of providing therapy services to residents of a hospital-attached nursing facility, when the services are billed separately from the nursing facility's payment rate or according to Minnesota Rules, parts 9500.0750 to 9500.1080, must be determined and deducted from the appropriate cost categories of the annual cost report based on the Medicare step-down as prepared in accordance with instructions provided by the commissioner.

History: *1976 c 282 s 7; 1977 c 305 s 45; 1977 c 326 s 15,16; 1979 c 35 s 1; 1980 c 570 s 2; 1982 c 424 s 130; 1983 c 199 s 13; 1987 c 403 art 2 s 91-93; 1989 c 282 art 3 s 79; 1992 c 513 art 7 s 136; 1Sp1993 c 1 art 5 s 102; 1999 c 220 s 50; 1Sp2003 c 14 art 3 s 44,45*

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

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reasonable attorney 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.

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(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 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

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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.

Subd. 1c. **Case mix rate for provider with addendum to provider agreement.** A nursing facility with an addendum to its provider agreement effective beginning July 1, 1983, or September 24, 1985, shall have its payment rates established by the commissioner under this subdivision. To save medical assistance resources, for rate years beginning after July 1, 1991, the provider's payment rates shall be the payment rates established by the commissioner July 1, 1990, multiplied by a 12-month inflation factor based on the forecasted inflation between the midpoints of rate years using the inflation index applied by the commissioner to other nursing facilities.

The provider and the Department of Health shall complete case mix assessments under Minnesota Rules, chapter 4656, and parts 9549.0058 and 9549.0059, on only those residents receiving medical assistance. The commissioner of health may audit and verify the limited provider assessments at any time.

Subd. 2. **Reporting requirements.** No later than December 31 of each year, a skilled nursing facility or intermediate care facility, including boarding care facilities, which receives medical assistance payments or other reimbursements from the state agency shall:

(1) provide the state agency with a copy of its audited financial statements. The audited financial statements must include a balance sheet, income statement, statement of the rate or rates charged to private paying residents, statement of retained earnings, statement of cash flows, notes to the financial statements, audited applicable supplemental information, and the certified public accountant's or licensed public accountant's opinion. The examination by the certified public accountant or licensed public accountant shall be conducted in accordance with generally accepted auditing standards as promulgated and adopted by the American Institute of Certified Public Accountants. Beginning with the reporting year which begins October 1, 1992, a nursing facility is no longer required to have a certified audit of its financial statements. The cost of a certified audit shall not be an allowable cost in that reporting year, nor in subsequent reporting years unless the nursing facility submits its certified audited financial statements in the manner otherwise specified in this subdivision. A nursing facility which does not submit a certified audit must submit its working trial balance;

(2) provide the state agency with a statement of ownership for the facility;

(3) provide the state agency with separate, audited financial statements as specified in clause (1) for every other facility owned in whole or part by an individual or entity which has an ownership interest in the facility;

(4) upon request, provide the state agency with separate, audited financial statements as specified in clause (1) for every organization with which the facility conducts business and which is owned in whole or in part by an individual or entity which has an ownership interest in the facility;

(5) provide the state agency with copies of leases, purchase agreements, and other documents related to the lease or purchase of the nursing facility;

(6) upon request, provide the state agency with copies of leases, purchase agreements, and other documents related to the acquisition of equipment, goods, and services which are claimed as allowable costs; and

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(7) permit access by the state agency to the certified public accountant's and licensed public accountant's audit work papers which support the audited financial statements required in clauses (1), (3), and (4).

Documents or information provided to the state agency pursuant to this subdivision shall be public. If the requirements of clauses (1) to (7) are not met, the reimbursement rate may be reduced to 80 percent of the rate in effect on the first day of the fourth calendar month after the close of the reporting year, and the reduction shall continue until the requirements are met.

Both nursing facilities and intermediate care facilities for the developmentally disabled must maintain statistical and accounting records in sufficient detail to support information contained in the facility's cost report for at least six years, including the year following the submission of the cost report. For computerized accounting systems, the records must include copies of electronically generated media such as magnetic discs and tapes.

Subd. 3. **Incomplete or inaccurate reports.** The commissioner may reject any annual cost report filed by a nursing facility pursuant to this chapter if the commissioner determines that the report or the information required in subdivision 2, clause (1), has been filed in a form that is incomplete or inaccurate. In the event that a report is rejected pursuant to this subdivision, the commissioner shall reduce the reimbursement rate to a nursing facility to 80 percent of its most recently established rate until the information is completely and accurately filed. The reinstatement of the total reimbursement rate is retroactive.

Subd. 3a. **Audit adjustments.** If the commissioner requests supporting documentation during an audit for an item of cost reported by a long-term care facility, and the long-term care facility's response does not adequately document the item of cost, the commissioner may make reasoned assumptions considered appropriate in the absence of the requested documentation to reasonably establish a payment rate rather than disallow the entire item of cost. This provision shall not diminish the long-term care facility's appeal rights.

Subd. 4. **Extensions.** The commissioner may grant up to a 15-day extension of the reporting deadline to a nursing facility for good cause. To receive such an extension, a nursing facility shall submit a written request by December 1. The commissioner will notify the nursing facility of the decision by December 15. Between December 1 and December 31, the nursing facility may request a reporting extension for good cause by telephone and followed by a written request.

Subd. 5. **False reports.** If a nursing facility knowingly supplies inaccurate or false information in a required report that results in an overpayment, the commissioner shall:

(1) immediately adjust the nursing facility's payment rate to recover the entire overpayment within the rate year; or

(2) terminate the commissioner's agreement with the nursing facility; or

(3) prosecute under applicable state or federal law; or

(4) use any combination of the foregoing actions.

Subd. 6. [Repealed, 2012 c 247 art 4 s 51]

Subd. 6a. **Referrals to Medicare providers required.** Notwithstanding subdivision 1, nursing facility providers that do not participate in or accept Medicare assignment must refer and document the referral of dual eligible recipients for whom placement is requested and for whom the resident would be qualified for a Medicare-covered stay to Medicare providers. The commissioner shall audit nursing facilities that do

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not accept Medicare and determine if dual eligible individuals with Medicare qualifying stays have been admitted. If such a determination is made, the commissioner shall deny Medicaid payment for the first 20 days of that resident's stay.

Subd. 7. **Refund of excess charges.** Any nursing facility which has charged a resident a rate for a case-mix classification upon admission which is in excess of the rate for the case-mix classification established by the commissioner of health and effective on the date of admission, must refund the amount of charge in excess of the rate for the case-mix classification established by the commissioner of health and effective on the date of admission. Refunds must be credited to the next monthly billing or refunded within 15 days of receipt of the classification notice from the Department of Health. Failure to refund the excess charge shall be considered to be a violation of this section.

Subd. 8. **Notification to a spouse or health care agent.** When a private pay resident who has not yet been screened by the preadmission screening team is admitted to a nursing facility or boarding care facility, the nursing facility or boarding care facility must notify the resident and the resident's spouse or health care agent of the following:

(1) their right to retain certain resources under sections 256B.0575, 256B.058, 256B.059, 256B.0595, and 256B.14, subdivision 2; and

(2) that the federal Medicare hospital insurance benefits program covers posthospital extended care services in a qualified skilled nursing facility for up to 150 days and that there are several limitations on this benefit. The resident and the resident's family or health care agent must be informed about all mechanisms to appeal limitations imposed under this federal benefit program.

This notice may be included in the nursing facility's or boarding care facility's admission agreement and must clearly explain what resources the resident and spouse may retain if the resident applies for medical assistance. The Department of Human Services must notify nursing facilities and boarding care facilities of changes in the determination of medical assistance eligibility that relate to resources retained by a resident and the resident's spouse.

The preadmission screening team has primary responsibility for informing all private pay applicants to a nursing facility or boarding care facility of the resources the resident and spouse may retain.

Subd. 9. [Repealed, 2000 c 449 s 15]

History: *1976 c 282 s 8; 1977 c 309 s 1; 1977 c 326 s 17; 1978 c 674 s 28; 1983 c 199 s 14; 1984 c 640 s 32; 1984 c 641 s 23; 1Sp1985 c 3 s 31; 1Sp1985 c 9 art 2 s 50-52; 1986 c 420 s 11,12; 1986 c 444; 1987 c 364 s 1; 1987 c 403 art 2 s 94; 1989 c 282 art 3 s 80-82; 1990 c 568 art 3 s 74,75; 1990 c 599 s 2; 1991 c 199 art 2 s 1; 1991 c 292 art 7 s 6; 1992 c 513 art 7 s 108-113,136; 1993 c 339 s 21; 1Sp1993 c 1 art 5 s 103,104; 1999 c 245 art 3 s 26-29; art 4 s 67; 2002 c 277 s 32; 2005 c 56 s 1; 2009 c 108 s 10; 2012 c 247 art 4 s 33*

256B.49 HOME AND COMMUNITY-BASED SERVICE WAIVERS FOR DISABLED.

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

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

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

Subd. 4. [Repealed, 1Sp2001 c 9 art 3 s 76]

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Subd. 5. [Repealed, 1Sp2001 c 9 art 3 s 76]

Subd. 6. [Repealed, 1Sp2001 c 9 art 3 s 76]

Subd. 7. [Repealed, 1Sp2001 c 9 art 3 s 76]

Subd. 8. [Repealed, 1Sp2001 c 9 art 3 s 76]

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

Subd. 10. [Repealed, 1Sp2001 c 9 art 3 s 76]

Subd. 11. **Authority.** (a) The commissioner is authorized to apply for home and community-based service waivers, as authorized under section 1915(c) of the Social Security Act to serve persons under the age of 65 who are determined to require the level of care provided in a nursing home and persons who require the level of care provided in a hospital. The commissioner shall apply for the home and community-based waivers in order to:

(1) promote the support of persons with disabilities in the most integrated settings;

(2) expand the availability of services for persons who are eligible for medical assistance;

(3) promote cost-effective options to institutional care; and

(4) obtain federal financial participation.

(b) The provision of waivered services to medical assistance recipients with disabilities shall comply with the requirements outlined in the federally approved applications for home and community-based services and subsequent amendments, including provision of services according to a service plan designed to meet the needs of the individual. For purposes of this section, the approved home and community-based application is considered the necessary federal requirement.

(c) The commissioner shall provide interested persons serving on agency advisory committees, task forces, the Centers for Independent Living, and others who request to be on a list to receive, notice of, and an opportunity to comment on, at least 30 days before any effective dates, (1) any substantive changes to the state's disability services program manual, or (2) changes or amendments to the federally approved applications for home and community-based waivers, prior to their submission to the federal Centers for Medicare and Medicaid Services.

(d) The commissioner shall seek approval, as authorized under section 1915(c) of the Social Security Act, to allow medical assistance eligibility under this section for children under age 21 without deeming of parental income or assets.

(e) The commissioner shall seek approval, as authorized under section 1915(c) of the Social Act, to allow medical assistance eligibility under this section for individuals under age 65 without deeming the spouse's income or assets.

Subd. 11a. **Waivered services statewide priorities.** (a) The commissioner shall establish statewide priorities for individuals on the waiting list for community alternative care, community alternatives for disabled individuals, and brain injury waiver services, as of January 1, 2010. The statewide priorities must include, but are not limited to, individuals who continue to have a need for waiver services after they have

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maximized the use of state plan services and other funding resources, including natural supports, prior to accessing waiver services, and who meet at least one of the following criteria:

(1) no longer require the intensity of services provided where they are currently living; or

(2) make a request to move from an institutional setting.

(b) After the priorities in paragraph (a) are met, priority must also be given to individuals who meet at least one of the following criteria:

(1) have unstable living situations due to the age, incapacity, or sudden loss of the primary caregivers;

(2) are moving from an institution due to bed closures;

(3) experience a sudden closure of their current living arrangement;

(4) require protection from confirmed abuse, neglect, or exploitation;

(5) experience a sudden change in need that can no longer be met through state plan services or other funding resources alone; or

(6) meet other priorities established by the department.

(c) When allocating resources to lead agencies, the commissioner must take into consideration the number of individuals waiting who meet statewide priorities and the lead agencies' current use of waiver funds and existing service options. The commissioner has the authority to transfer funds between counties, groups of counties, and tribes to accommodate statewide priorities and resource needs while accounting for a necessary base level reserve amount for each county, group of counties, and tribe.

Subd. 12. **Informed choice.** Persons who are determined likely to require the level of care provided in a nursing facility as determined under section 256B.0911, subdivision 4e, or a hospital shall be informed of the home and community-based support alternatives to the provision of inpatient hospital services or nursing facility services. Each person must be given the choice of either institutional or home and community-based services using the provisions described in section 256B.77, subdivision 2, paragraph (p).

Subd. 13. **Case management.** (a) Each recipient of a home and community-based waiver shall be provided case management services by qualified vendors as described in the federally approved waiver application. The case management service activities provided must include:

(1) finalizing the written coordinated service and support plan within ten working days after the case manager receives the plan from the certified assessor;

(2) informing the recipient or the recipient's legal guardian or conservator of service options;

(3) assisting the recipient in the identification of potential service providers and available options for case management service and providers;

(4) assisting the recipient to access services and assisting with appeals under section 256.045; and

(5) coordinating, evaluating, and monitoring of the services identified in the service plan.

(b) The case manager may delegate certain aspects of the case management service activities to another individual provided there is oversight by the case manager. The case manager may not delegate those aspects which require professional judgment including:

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(1) finalizing the coordinated service and support plan;

(2) ongoing assessment and monitoring of the person's needs and adequacy of the approved coordinated service and support plan; and

(3) adjustments to the coordinated service and support plan.

(c) Case management services must be provided by a public or private agency that is enrolled as a medical assistance provider determined by the commissioner to meet all of the requirements in the approved federal waiver plans. Case management services must not be provided to a recipient by a private agency that has any financial interest in the provision of any other services included in the recipient's coordinated service and support plan. For purposes of this section, "private agency" means any agency that is not identified as a lead agency under section 256B.0911, subdivision 1a, paragraph (e).

(d) For persons who need a positive support transition plan as required in chapter 245D, the case manager shall participate in the development and ongoing evaluation of the plan with the expanded support team. At least quarterly, the case manager, in consultation with the expanded support team, shall evaluate the effectiveness of the plan based on progress evaluation data submitted by the licensed provider to the case manager. The evaluation must identify whether the plan has been developed and implemented in a manner to achieve the following within the required timelines:

(1) phasing out the use of prohibited procedures;

(2) acquisition of skills needed to eliminate the prohibited procedures within the plan's timeline; and

(3) accomplishment of identified outcomes.

If adequate progress is not being made, the case manager shall consult with the person's expanded support team to identify needed modifications and whether additional professional support is required to provide consultation.

Subd. 14. **Assessment and reassessment.** (a) Assessments and reassessments shall be conducted by certified assessors according to section 256B.0911, subdivision 2b. The certified assessor, with the permission of the recipient or the recipient's designated legal representative, may invite other individuals to attend the assessment. With the permission of the recipient or the recipient's designated legal representative, the recipient's current provider of services may submit a written report outlining their recommendations regarding the recipient's care needs prepared by a direct service employee with at least 20 hours of service to that client. The certified assessor must notify the provider of the date by which this information is to be submitted. This information shall be provided to the certified assessor and the person or the person's legal representative and must be considered prior to the finalization of the assessment or reassessment.

(b) There must be a determination that the client requires a hospital level of care or a nursing facility level of care as defined in section 256B.0911, subdivision 4e, at initial and subsequent assessments to initiate and maintain participation in the waiver program.

(c) Regardless of other assessments identified in section 144.0724, subdivision 4, as appropriate to determine nursing facility level of care for purposes of medical assistance payment for nursing facility services, only face-to-face assessments conducted according to section 256B.0911, subdivisions 3a, 3b, and 4d, that result in a hospital level of care determination or a nursing facility level of care determination must be accepted for purposes of initial and ongoing access to waiver services payment.

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(d) Recipients who are found eligible for home and community-based services under this section before their 65th birthday may remain eligible for these services after their 65th birthday if they continue to meet all other eligibility factors.

Subd. 15. **Coordinated service and support plan; comprehensive transitional service plan; maintenance service plan.** (a) Each recipient of home and community-based waivered services shall be provided a copy of the written coordinated service and support plan which meets the requirements in section 256B.092, subdivision 1b.

(b) In developing the comprehensive transitional service plan, the individual receiving services, the case manager, and the guardian, if applicable, will identify the transitional service plan fundamental service outcome and anticipated timeline to achieve this outcome. Within the first 20 days following a recipient's request for an assessment or reassessment, the transitional service planning team must be identified. A team leader must be identified who will be responsible for assigning responsibility and communicating with team members to ensure implementation of the transition plan and ongoing assessment and communication process. The team leader should be an individual, such as the case manager or guardian, who has the opportunity to follow the recipient to the next level of service.

Within ten days following an assessment, a comprehensive transitional service plan must be developed incorporating elements of a comprehensive functional assessment and including short-term measurable outcomes and timelines for achievement of and reporting on these outcomes. Functional milestones must also be identified and reported according to the timelines agreed upon by the transitional service planning team. In addition, the comprehensive transitional service plan must identify additional supports that may assist in the achievement of the fundamental service outcome such as the development of greater natural community support, increased collaboration among agencies, and technological supports.

The timelines for reporting on functional milestones will prompt a reassessment of services provided, the units of services, rates, and appropriate service providers. It is the responsibility of the transitional service planning team leader to review functional milestone reporting to determine if the milestones are consistent with observable skills and that milestone achievement prompts any needed changes to the comprehensive transitional service plan.

For those whose fundamental transitional service outcome involves the need to procure housing, a plan for the recipient to seek the resources necessary to secure the least restrictive housing possible should be incorporated into the plan, including employment and public supports such as housing access and shelter needy funding.

(c) Counties and other agencies responsible for funding community placement and ongoing community supportive services are responsible for the implementation of the comprehensive transitional service plans. Oversight responsibilities include both ensuring effective transitional service delivery and efficient utilization of funding resources.

(d) Following one year of transitional services, the transitional services planning team will make a determination as to whether or not the individual receiving services requires the current level of continuous and consistent support in order to maintain the recipient's current level of functioning. Recipients who are determined to have not had a significant change in functioning for 12 months must move from a transitional to a maintenance service plan. Recipients on a maintenance service plan must be reassessed to determine if the recipient would benefit from a transitional service plan at least every 12 months and at other times when there has been a significant change in the recipient's functioning. This assessment should consider any changes to technological or natural community supports.

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(e) When a county is evaluating denials, reductions, or terminations of home and community-based services under this section for an individual, the case manager shall offer to meet with the individual or the individual's guardian in order to discuss the prioritization of service needs within the coordinated service and support plan, comprehensive transitional service plan, or maintenance service plan. The reduction in the authorized services for an individual due to changes in funding for waivered services may not exceed the amount needed to ensure medically necessary services to meet the individual's health, safety, and welfare.

(f) At the time of reassessment, local agency case managers shall assess each recipient of community alternatives for disabled individuals or brain injury waivered services currently residing in a licensed adult foster home that is not the primary residence of the license holder, or in which the license holder is not the primary caregiver, to determine if that recipient could appropriately be served in a community-living setting. If appropriate for the recipient, the case manager shall offer the recipient, through a person-centered planning process, the option to receive alternative housing and service options. In the event that the recipient chooses to transfer from the adult foster home, the vacated bed shall not be filled with another recipient of waiver services and group residential housing and the licensed capacity shall be reduced accordingly, unless the savings required by the licensed bed closure reductions under Laws 2011, First Special Session chapter 9, article 7, sections 1 and 40, paragraph (f), for foster care settings where the physical location is not the primary residence of the license holder are met through voluntary changes described in section 245A.03, subdivision 7, paragraph (e), or as provided under paragraph (a), clauses (3) and (4). If the adult foster home becomes no longer viable due to these transfers, the county agency, with the assistance of the department, shall facilitate a consolidation of settings or closure. This reassessment process shall be completed by July 1, 2013.

Subd. 16. **Services and supports.** (a) Services and supports included in the home and community-based waivers for persons with disabilities shall meet the requirements set out in United States Code, title 42, section 1396n. The services and supports, which are offered as alternatives to institutional care, shall promote consumer choice, community inclusion, self-sufficiency, and self-determination.

(b) Beginning January 1, 2003, the commissioner shall simplify and improve access to home and community-based waivered services, to the extent possible, through the establishment of a common service menu that is available to eligible recipients regardless of age, disability type, or waiver program.

(c) Consumer directed community support services shall be offered as an option to all persons eligible for services under subdivision 11, by January 1, 2002.

(d) Services and supports shall be arranged and provided consistent with individualized written plans of care for eligible waiver recipients.

(e) A transitional supports allowance shall be available to all persons under a home and community-based waiver who are moving from a licensed setting to a community setting. "Transitional supports allowance" means a onetime payment of up to $3,000, to cover the costs, not covered by other sources, associated with moving from a licensed setting to a community setting. Covered costs include:

(1) lease or rent deposits;

(2) security deposits;

(3) utilities setup costs, including telephone;

(4) essential furnishings and supplies; and

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(5) personal supports and transports needed to locate and transition to community settings.

(f) The state of Minnesota and county agencies that administer home and community-based waivered services for persons with disabilities, shall not be liable for damages, injuries, or liabilities sustained through the purchase of supports by the individual, the individual's family, legal representative, or the authorized representative with funds received through the consumer-directed community support service under this section. Liabilities include but are not limited to: workers' compensation liability, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA).

Subd. 16a. [Repealed, 2013 c 108 art 9 s 16]

Subd. 17. **Cost of services and supports.** (a) The commissioner shall ensure that the average per capita expenditures estimated in any fiscal year for home and community-based waiver recipients does not exceed the average per capita expenditures that would have been made to provide institutional services for recipients in the absence of the waiver.

(b) The commissioner shall implement on January 1, 2002, one or more aggregate, need-based methods for allocating to local agencies the home and community-based waivered service resources available to support recipients with disabilities in need of the level of care provided in a nursing facility or a hospital. The commissioner shall allocate resources to single counties and county partnerships in a manner that reflects consideration of:

(1) an incentive-based payment process for achieving outcomes;

(2) the need for a state-level risk pool;

(3) the need for retention of management responsibility at the state agency level; and

(4) a phase-in strategy as appropriate.

(c) Until the allocation methods described in paragraph (b) are implemented, the annual allowable reimbursement level of home and community-based waiver services shall be the greater of:

(1) the statewide average payment amount which the recipient is assigned under the waiver reimbursement system in place on June 30, 2001, modified by the percentage of any provider rate increase appropriated for home and community-based services; or

(2) an amount approved by the commissioner based on the recipient's extraordinary needs that cannot be met within the current allowable reimbursement level. The increased reimbursement level must be necessary to allow the recipient to be discharged from an institution or to prevent imminent placement in an institution. The additional reimbursement may be used to secure environmental modifications; assistive technology and equipment; and increased costs for supervision, training, and support services necessary to address the recipient's extraordinary needs. The commissioner may approve an increased reimbursement level for up to one year of the recipient's relocation from an institution or up to six months of a determination that a current waiver recipient is at imminent risk of being placed in an institution.

(d) Beginning July 1, 2001, medically necessary home care nursing services will be authorized under this section as complex and regular care according to sections 256B.0651 to 256B.0654 and 256B.0659. The rate established by the commissioner for registered nurse or licensed practical nurse services under any home and community-based waiver as of January 1, 2001, shall not be reduced.

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(e) Notwithstanding section 252.28, subdivision 3, paragraph (d), if the 2009 legislature adopts a rate reduction that impacts payment to providers of adult foster care services, the commissioner may issue adult foster care licenses that permit a capacity of five adults. The application for a five-bed license must meet the requirements of section 245A.11, subdivision 2a. Prior to admission of the fifth recipient of adult foster care services, the county must negotiate a revised per diem rate for room and board and waiver services that reflects the legislated rate reduction and results in an overall average per diem reduction for all foster care recipients in that home. The revised per diem must allow the provider to maintain, as much as possible, the level of services or enhanced services provided in the residence, while mitigating the losses of the legislated rate reduction.

Subd. 18. **Payments.** The commissioner shall reimburse approved vendors from the medical assistance account for the costs of providing home and community-based services to eligible recipients using the invoice processing procedures of the Medicaid management information system (MMIS). Recipients will be screened and authorized for services according to the federally approved waiver application and its subsequent amendments.

Subd. 19. **Health and welfare.** The commissioner of human services shall take the necessary safeguards to protect the health and welfare of individuals provided services under the waiver.

Subd. 20. **Brain injury and related conditions.** The commissioner shall seek to amend the brain injury waiver to include, as eligible persons, individuals with an acquired or degenerative disease diagnosis where cognitive impairment is present, such as multiple sclerosis.

Subd. 21. MS 2012 [Expired]

Subd. 22. **Residential support services.** For the purposes of this section, the provisions of section 256B.092, subdivision 11, are controlling.

Subd. 23. **Community-living settings.** "Community-living settings" means a single-family home or apartment where the service recipient or their family owns or rents, and maintains control over the individual unit as demonstrated by the lease agreement, or has a plan for transition of a lease from a service provider to the individual. Within two years of signing the initial lease, the service provider shall transfer the lease to the individual. In the event the landlord denies the transfer, the commissioner may approve an exception within sufficient time to ensure the continued occupancy by the individual. Community-living settings are subject to the following:

(1) individuals are not required to receive services;

(2) individuals are not required to have a disability or specific diagnosis to live in the community-living setting;

(3) individuals may hire service providers of their choice;

(4) individuals may choose whether to share their household and with whom;

(5) the home or apartment must include living, sleeping, bathing, and cooking areas;

(6) individuals must have lockable access and egress;

(7) individuals must be free to receive visitors and leave the settings at times and for durations of their own choosing;

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(8) leases must not reserve the right to assign units or change unit assignments; and

(9) access to the greater community must be easily facilitated based on the individual's needs and preferences.

Subd. 24. **Waiver allocations for transition populations.** (a) The commissioner shall make available additional waiver allocations and additional necessary resources to assure timely discharges from the Anoka Metro Regional Treatment Center and the Minnesota Security Hospital in St. Peter for individuals who meet the following criteria:

(1) are otherwise eligible for the brain injury, community alternatives for disabled individuals, or community alternative care waivers under this section;

(2) who would otherwise remain at the Anoka Metro Regional Treatment Center or the Minnesota Security Hospital;

(3) whose discharge would be significantly delayed without the available waiver allocation; and

(4) who have met treatment objectives and no longer meet hospital level of care.

(b) Additional waiver allocations under this subdivision must meet cost-effectiveness requirements of the federal approved waiver plan.

(c) Any corporate foster care home developed under this subdivision must be considered an exception under section 245A.03, subdivision 7, paragraph (a).

Subd. 25. **Reduce avoidable behavioral crisis emergency room admissions, psychiatric inpatient hospitalizations, and commitments to institutions.** (a) Persons receiving home and community-based services authorized under this section who have two or more admissions within a calendar year to an emergency room, psychiatric unit, or institution must receive consultation from a mental health professional as defined in section 245.462, subdivision 18, or a behavioral professional as defined in the home and community-based services state plan within 30 days of discharge. The mental health professional or behavioral professional must:

(1) conduct a functional assessment of the crisis incident as defined in section 245D.02, subdivision 11, which led to the hospitalization with the goal of developing proactive strategies as well as necessary reactive strategies to reduce the likelihood of future avoidable hospitalizations due to a behavioral crisis;

(2) use the results of the functional assessment to amend the coordinated service and support plan in section 245D.02, subdivision 4b, to address the potential need for additional staff training, increased staffing, access to crisis mobility services, mental health services, use of technology, and crisis stabilization services in section 256B.0624, subdivision 7; and

(3) identify the need for additional consultation, testing, mental health crisis intervention team services as defined in section 245D.02, subdivision 20, psychotropic medication use and monitoring under section 245D.051, and the frequency and duration of ongoing consultation.

(b) For the purposes of this subdivision, "institution" includes, but is not limited to, the Anoka-Metro Regional Treatment Center and the Minnesota Security Hospital.

Subd. 26. **Excess allocations.** County and tribal agencies will be responsible for authorizations in excess of the allocation made by the commissioner. In the event a county or tribal agency authorizes in excess of

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the allocation made by the commissioner for a given allocation period, the county or tribal agency must submit a corrective action plan to the commissioner. The plan must state the actions the agency will take to correct their overspending for the year following the period when the overspending occurred. Failure to correct overauthorizations shall result in recoupment of authorizations in excess of the allocation. Nothing in this subdivision shall be construed as reducing the county's responsibility to offer and make available feasible home and community-based options to eligible waiver recipients within the resources allocated to them for that purpose.

History: *1984 c 640 s 32; 1984 c 654 art 5 s 24,58; 1990 c 568 art 3 s 76; 1991 c 292 art 4 s 61; 1992 c 513 art 7 s 114; 1Sp1993 c 1 art 5 s 105; 1995 c 207 art 6 s 87-89; 1996 c 451 art 5 s 29-31; 1997 c 7 art 5 s 31; 1997 c 203 art 4 s 47; art 7 s 24; 1999 c 156 s 1; 1Sp2001 c 9 art 3 s 58-67; 2002 c 277 s 32; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 3 s 46; 2004 c 288 art 3 s 25; 2005 c 56 s 1; 1Sp2005 c 4 art 7 s 44; 2007 c 147 art 6 s 45; art 7 s 58; 2008 c 277 art 1 s 39; 2008 c 317 s 2; 2009 c 79 art 1 s 19; art 6 s 13; art 8 s 64-68; 2009 c 173 art 1 s 30; 1Sp2011 c 9 art 4 s 9; art 7 s 38-41; 2012 c 216 art 9 s 29; art 11 s 38-40; art 14 s 2; 2012 c 247 art 4 s 34-36; 2013 c 63 s 15; 2013 c 108 art 2 s 37,38,44; art 4 s 27; art 7 s 38-42; art 8 s 51; art 15 s 3,4; 2014 c 262 art 5 s 6; 2014 c 291 art 9 s 5*

256B.491 [Repealed, 2014 c 262 art 4 s 9]

256B.4912 HOME AND COMMUNITY-BASED WAIVERS; PROVIDERS AND PAYMENT.

Subdivision 1. **Provider qualifications.** (a) For the home and community-based waivers providing services to seniors and individuals with disabilities under sections 256B.0913, 256B.0915, 256B.092, and 256B.49, the commissioner shall establish:

(1) agreements with enrolled waiver service providers to ensure providers meet Minnesota health care program requirements;

(2) regular reviews of provider qualifications, and including requests of proof of documentation; and

(3) processes to gather the necessary information to determine provider qualifications.

(b) Beginning July 1, 2012, staff that provide direct contact, as defined in section 245C.02, subdivision 11, for services specified in the federally approved waiver plans must meet the requirements of chapter 245C prior to providing waiver services and as part of ongoing enrollment. Upon federal approval, this requirement must also apply to consumer-directed community supports.

(c) Beginning January 1, 2014, service owners and managerial officials overseeing the management or policies of services that provide direct contact as specified in the federally approved waiver plans must meet the requirements of chapter 245C prior to reenrollment or revalidation or, for new providers, prior to initial enrollment if they have not already done so as a part of service licensure requirements.

Subd. 2. **Payment methodologies.** (a) The commissioner shall establish, as defined under section 256B.4914, statewide payment methodologies that meet federal waiver requirements for home and community-based waiver services for individuals with disabilities. The payment methodologies must abide by the principles of transparency and equitability across the state. The methodologies must involve a uniform process of structuring rates for each service and must promote quality and participant choice.

(b) As of January 1, 2012, counties shall not implement changes to established processes for rate-setting methodologies for individuals using components of or data from research rates.

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Subd. 3. **Payment requirements.** The payment methodologies established under this section shall accommodate:

(1) supervision costs;

(2) staff compensation;

(3) staffing and supervisory patterns;

(4) program-related expenses;

(5) general and administrative expenses; and

(6) consideration of recipient intensity.

Subd. 4. **Payment rate criteria.** (a) The payment methodologies under this section shall reflect the payment rate criteria in paragraphs (b), (c), and (d).

(b) Payment rates shall reflect the reasonable, ordinary, and necessary costs of service delivery.

(c) Payment rates shall be sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area as required by section 1902(a)(30)(A) of the Social Security Act.

(d) The commissioner must not reimburse:

(1) unauthorized service delivery;

(2) services provided under a receipt of a special grant;

(3) services provided under contract to a local school district;

(4) extended employment services under Minnesota Rules, parts 3300.2005 to 3300.3100, or vocational rehabilitation services provided under the federal Rehabilitation Act, as amended, Title I, section 110, or Title VI-C, and not through use of medical assistance or county social service funds; or

(5) services provided to a client by a licensed medical, therapeutic, or rehabilitation practitioner or any other vendor of medical care which are billed separately on a fee-for-service basis.

Subd. 5. **County and tribal provider contract elimination.** County and tribal contracts with providers of home and community-based waiver services provided under sections 256B.0913, 256B.0915, 256B.092, and 256B.49 are eliminated effective January 1, 2014.

Subd. 6. **Program standards.** The commissioner of human services must establish uniform program standards for services identified in chapter 245D for persons with disabilities and people age 65 and older. The commissioner must grant licenses according to the provisions of chapter 245A.

Subd. 7. **Applicant and license holder training.** An applicant or license holder for the home and community-based waivers providing services to seniors and individuals with disabilities under sections 256B.0913, 256B.0915, 256B.092, and 256B.49 that is not enrolled as a Minnesota health care program home and community-based services waiver provider at the time of application must ensure that at least one controlling individual completes a onetime training on the requirements for providing home and community-based services as determined by the commissioner, before a provider is enrolled or license is issued. Within

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six months of enrollment, a newly enrolled home and community-based waiver service provider must ensure that at least one controlling individual has completed training on waiver and related program billing. Exemptions to new waiver provider training requirements may be granted, as determined by the commissioner.

Subd. 8. **Data on use of emergency use of manual restraint.** Beginning July 1, 2013, facilities and services to be licensed under chapter 245D shall submit data regarding the use of emergency use of manual restraint as identified in section 245D.061 in a format and at a frequency identified by the commissioner.

Subd. 9. **Definitions.** (a) For the purposes of this section, the following terms have the meanings given them.

(b) "Controlling individual" means a public body, governmental agency, business entity, officer, owner, or managerial official whose responsibilities include the direction of the management or policies of a program.

(c) "Managerial official" means an individual who has decision-making authority related to the operation of the program and responsibility for the ongoing management of or direction of the policies, services, or employees of the program.

(d) "Owner" means an individual who has direct or indirect ownership interest in a corporation or partnership, or business association enrolling with the Department of Human Services as a provider of waiver services.

Subd. 10. **Enrollment requirements.** (a) Except as provided in paragraph (b), the following home and community-based waiver providers must provide, at the time of enrollment and within 30 days of a request, in a format determined by the commissioner, information and documentation that includes proof of liability insurance:

(1) waiver services providers required to meet the provider standards in chapter 245D;

(2) foster care providers whose services are funded by the elderly waiver or alternative care program;

(3) fiscal support entities;

(4) adult day care providers;

(5) providers of customized living services; and

(6) residential care providers.

(b) Providers of foster care services covered by section 245.814 are exempt from this subdivision.

History: *2009 c 79 art 8 s 69; 2012 c 216 art 18 s 26; 2013 c 108 art 8 s 52-56; art 13 s 7,8; 2014 c 291 art 8 s 9; 2014 c 312 art 27 s 60*

256B.4913 PAYMENT METHODOLOGY DEVELOPMENT.

Subdivision 1. [Repealed, 2013 c 108 art 13 s 14]

Subd. 2. [Repealed, 2013 c 108 art 13 s 14]

Subd. 3. [Repealed, 2013 c 108 art 13 s 14]

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Subd. 4. [Repealed, 2013 c 108 art 13 s 14]

Subd. 4a. **Rate stabilization adjustment.** (a) For purposes of this subdivision, "implementation period" means the period beginning January 1, 2014, and ending on the last day of the month in which the rate management system is populated with the data necessary to calculate rates for substantially all individuals receiving home and community-based waiver services under sections 256B.092 and 256B.49. "Banding period" means the time period beginning on January 1, 2014, and ending upon the expiration of the 12-month period defined in paragraph (c), clause (5).

(b) For purposes of this subdivision, the historical rate for all service recipients means the individual reimbursement rate for a recipient in effect on December 1, 2013, except that:

(1) for a day service recipient who was not authorized to receive these waiver services prior to January 1, 2014; added a new service or services on or after January 1, 2014; or changed providers on or after January 1, 2014, the historical rate must be the authorized rate for the provider in the county of service, effective December 1, 2013; or

(2) for a unit-based service with programming or a unit-based service without programming recipient who was not authorized to receive these waiver services prior to January 1, 2014; added a new service or services on or after January 1, 2014; or changed providers on or after January 1, 2014, the historical rate must be the weighted average authorized rate for each provider number in the county of service, effective December 1, 2013; or

(3) for residential service recipients who change providers on or after January 1, 2014, the historical rate must be set by each lead agency within their county aggregate budget using their respective methodology for residential services effective December 1, 2013, for determining the provider rate for a similarly situated recipient being served by that provider.

(c) The commissioner shall adjust individual reimbursement rates determined under this section so that the unit rate is no higher or lower than:

(1) 0.5 percent from the historical rate for the implementation period;

(2) 0.5 percent from the rate in effect in clause (1), for the 12-month period immediately following the time period of clause (1);

(3) 1.0 percent from the rate in effect in clause (2), for the 12-month period immediately following the time period of clause (2);

(4) 1.0 percent from the rate in effect in clause (3), for the 12-month period immediately following the time period of clause (3); and

(5) 1.0 percent from the rate in effect in clause (4), for the 12-month period immediately following the time period of clause (4).

(d) The commissioner shall review all changes to rates that were in effect on December 1, 2013, to verify that the rates in effect produce the equivalent level of spending and service unit utilization on an annual basis as those in effect on October 31, 2013.

(e) By December 31, 2014, the commissioner shall complete the review in paragraph (d), adjust rates to provide equivalent annual spending, and make appropriate adjustments.

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(f) During the banding period, the Medicaid Management Information System (MMIS) service agreement rate must be adjusted to account for change in an individual's need. The commissioner shall adjust the Medicaid Management Information System (MMIS) service agreement rate by:

(1) calculating a service rate under section 256B.4914, subdivision 6, 7, 8, or 9, for the individual with variables reflecting the level of service in effect on December 1, 2013;

(2) calculating a service rate under section 256B.4914, subdivision 6, 7, 8, or 9, for the individual with variables reflecting the updated level of service at the time of application; and

(3) adding to or subtracting from the Medicaid Management Information System (MMIS) service agreement rate, the difference between the values in clauses (1) and (2).

(g) This subdivision must not apply to rates for recipients served by providers new to a given county after January 1, 2014. Providers of personal supports services who also acted as fiscal support entities must be treated as new providers as of January 1, 2014.

Subd. 5. **Stakeholder consultation.** The commissioner shall continue consultation on regular intervals with the existing stakeholder group established as part of the rate-setting methodology process and others, to gather input, concerns, and data, to assist in the full implementation of the new rate payment system and to make pertinent information available to the public through the department's Web site.

Subd. 6. **Implementation.** (a) The commissioner shall implement changes on January 1, 2014, to payment rates for individuals receiving home and community-based waivered services after the enactment of legislation that establishes specific payment methodology frameworks, processes for rate calculations, and specific values to populate the disability waiver rates system.

(b) On January 1, 2014, all new service authorizations must use the disability waiver rates system. Beginning January 1, 2014, all renewing individual service plans must use the disability waiver rates system as reassessment and reauthorization occurs. By December 31, 2014, data for all recipients must be entered into the disability waiver rates system.

History: *2012 c 216 art 18 s 27; 2013 c 108 art 13 s 9-11; 2014 c 312 art 27 s 61*

256B.4914 HOME AND COMMUNITY-BASED SERVICES WAIVERS; RATE SETTING.

Subdivision 1. **Application.** The payment methodologies in this section apply to home and community-based services waivers under sections 256B.092 and 256B.49. This section does not change existing waiver policies and procedures.

Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the meanings given them, unless the context clearly indicates otherwise.

(b) "Commissioner" means the commissioner of human services.

(c) "Component value" means underlying factors that are part of the cost of providing services that are built into the waiver rates methodology to calculate service rates.

(d) "Customized living tool" means a methodology for setting service rates that delineates and documents the amount of each component service included in a recipient's customized living service plan.

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(e) "Disability waiver rates system" means a statewide system that establishes rates that are based on uniform processes and captures the individualized nature of waiver services and recipient needs.

(f) "Individual staffing" means the time spent as a one-to-one interaction specific to an individual recipient by staff brought in solely to provide direct support and assistance with activities of daily living, instrumental activities of daily living, and training to participants, and is based on the requirements in each individual's coordinated service and support plan under section 245D.02, subdivision 4b; any coordinated service and support plan addendum under section 245D.02, subdivision 4c; an assessment tool; and provider observation of an individual's needs.

(g) "Lead agency" means a county, partnership of counties, or tribal agency charged with administering waivered services under sections 256B.092 and 256B.49.

(h) "Median" means the amount that divides distribution into two equal groups, one-half above the median and one-half below the median.

(i) "Payment or rate" means reimbursement to an eligible provider for services provided to a qualified individual based on an approved service authorization.

(j) "Rates management system" means a Web-based software application that uses a framework and component values, as determined by the commissioner, to establish service rates.

(k) "Recipient" means a person receiving home and community-based services funded under any of the disability waivers.

(l) "Shared staffing" means time spent by employees, not defined under paragraph (f), providing or available to provide more than one individual with direct support and assistance with activities of daily living as defined under section 256B.0659, subdivision 1, paragraph (b); instrumental activities of daily living as defined under section 256B.0659, subdivision 1, paragraph (i); ancillary activities needed to support individual services; and training to participants, and is based on the requirements in each individual's coordinated service and support plan under section 245D.02, subdivision 4b; any coordinated service and support plan addendum under section 245D.02, subdivision 4c; an assessment tool; and provider observation of an individual's service need. Total shared staffing hours are divided proportionally by the number of individuals who receive the shared service provisions.

(m) "Staffing ratio" means the number of recipients a service provider employee supports during a unit of service based on a uniform assessment tool, provider observation, case history, and the recipient's services of choice, and not based on the staffing ratios under section 245D.31.

(n) "Unit of service" means the following:

(1) for residential support services under subdivision 6, a unit of service is a day. Any portion of any calendar day, within allowable Medicaid rules, where an individual spends time in a residential setting is billable as a day;

(2) for day services under subdivision 7:

(i) for day training and habilitation services, a unit of service is either:

(A) a day unit of service is defined as six or more hours of time spent providing direct services and transportation; or

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(B) a partial day unit of service is defined as fewer than six hours of time spent providing direct services and transportation; and

(C) for new day service recipients after January 1, 2014, 15 minute units of service must be used for fewer than six hours of time spent providing direct services and transportation;

(ii) for adult day and structured day services, a unit of service is a day or 15 minutes. A day unit of service is six or more hours of time spent providing direct services;

(iii) for prevocational services, a unit of service is a day or an hour. A day unit of service is six or more hours of time spent providing direct service;

(3) for unit-based services with programming under subdivision 8:

(i) for supported living services, a unit of service is a day or 15 minutes. When a day rate is authorized, any portion of a calendar day where an individual receives services is billable as a day; and

(ii) for all other services, a unit of service is 15 minutes; and

(4) for unit-based services without programming under subdivision 9:

(i) for respite services, a unit of service is a day or 15 minutes. When a day rate is authorized, any portion of a calendar day when an individual receives services is billable as a day; and

(ii) for all other services, a unit of service is 15 minutes.

Subd. 3. **Applicable services.** Applicable services are those authorized under the state's home and community-based services waivers under sections 256B.092 and 256B.49, including the following, as defined in the federally approved home and community-based services plan:

(1) 24-hour customized living;

(2) adult day care;

(3) adult day care bath;

(4) behavioral programming;

(5) companion services;

(6) customized living;

(7) day training and habilitation;

(8) housing access coordination;

(9) independent living skills;

(10) in-home family support;

(11) night supervision;

(12) personal support;

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(13) prevocational services;

(14) residential care services;

(15) residential support services;

(16) respite services;

(17) structured day services;

(18) supported employment services;

(19) supported living services;

(20) transportation services; and

(21) other services as approved by the federal government in the state home and community-based services plan.

Subd. 4. **Data collection for rate determination.** (a) Rates for applicable home and community-based waivered services, including rate exceptions under subdivision 12, are set by the rates management system.

(b) Data for services under section 256B.4913, subdivision 4a, shall be collected in a manner prescribed by the commissioner.

(c) Data and information in the rates management system may be used to calculate an individual's rate.

(d) Service providers, with information from the community support plan and oversight by lead agencies, shall provide values and information needed to calculate an individual's rate into the rates management system. The determination of service levels must be part of a discussion with members of the support team as defined in section 245D.02, subdivision 34. This discussion must occur prior to the final establishment of each individual's rate. The values and information include:

(1) shared staffing hours;

(2) individual staffing hours;

(3) direct registered nurse hours;

(4) direct licensed practical nurse hours;

(5) staffing ratios;

(6) information to document variable levels of service qualification for variable levels of reimbursement in each framework;

(7) shared or individualized arrangements for unit-based services, including the staffing ratio;

(8) number of trips and miles for transportation services; and

(9) service hours provided through monitoring technology.

(e) Updates to individual data must include:

(1) data for each individual that is updated annually when renewing service plans; and

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(2) requests by individuals or lead agencies to update a rate whenever there is a change in an individual's service needs, with accompanying documentation.

(f) Lead agencies shall review and approve all services reflecting each individual's needs, and the values to calculate the final payment rate for services with variables under subdivisions 6, 7, 8, and 9 for each individual. Lead agencies must notify the individual and the service provider of the final agreed-upon values and rate, and provide information that is identical to what was entered into the rates management system. If a value used was mistakenly or erroneously entered and used to calculate a rate, a provider may petition lead agencies to correct it. Lead agencies must respond to these requests. When responding to the request, the lead agency must consider:

(1) meeting the health and welfare needs of the individual or individuals receiving services by service site, identified in their coordinated service and support plan under section 245D.02, subdivision 4b, and any addendum under section 245D.02, subdivision 4c;

(2) meeting the requirements for staffing under subdivision 2, paragraphs (f), (i), and (m); and meeting or exceeding the licensing standards for staffing required under section 245D.09, subdivision 1; and

(3) meeting the staffing ratio requirements under subdivision 2, paragraph (n), and meeting or exceeding the licensing standards for staffing required under section 245D.31.

Subd. 5. **Base wage index and standard component values.** (a) The base wage index is established to determine staffing costs associated with providing services to individuals receiving home and community-based services. For purposes of developing and calculating the proposed base wage, Minnesota-specific wages taken from job descriptions and standard occupational classification (SOC) codes from the Bureau of Labor Statistics as defined in the most recent edition of the Occupational Handbook must be used. The base wage index must be calculated as follows:

(1) for residential direct care staff, the sum of:

(i) 15 percent of the subtotal of 50 percent of the median wage for personal and home health aide (SOC code 39-9021); 30 percent of the median wage for nursing aide (SOC code 31-1012); and 20 percent of the median wage for social and human services aide (SOC code 21-1093); and

(ii) 85 percent of the subtotal of 20 percent of the median wage for home health aide (SOC code 31-1011); 20 percent of the median wage for personal and home health aide (SOC code 39-9021); 20 percent of the median wage for nursing aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(2) for day services, 20 percent of the median wage for nursing aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(3) for residential asleep-overnight staff, the wage will be $7.66 per hour, except in a family foster care setting, the wage is $2.80 per hour;

(4) for behavior program analyst staff, 100 percent of the median wage for mental health counselors (SOC code 21-1014);

(5) for behavior program professional staff, 100 percent of the median wage for clinical counseling and school psychologist (SOC code 19-3031);

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(6) for behavior program specialist staff, 100 percent of the median wage for psychiatric technicians (SOC code 29-2053);

(7) for supportive living services staff, 20 percent of the median wage for nursing aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(8) for housing access coordination staff, 50 percent of the median wage for community and social services specialist (SOC code 21-1099); and 50 percent of the median wage for social and human services aide (SOC code 21-1093);

(9) for in-home family support staff, 20 percent of the median wage for nursing aide (SOC code 31-1012); 30 percent of the median wage for community social service specialist (SOC code 21-1099); 40 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

(10) for independent living skills staff, 40 percent of the median wage for community social service specialist (SOC code 21-1099); 50 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

(11) for supported employment staff, 20 percent of the median wage for nursing aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(12) for adult companion staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing aides, orderlies, and attendants (SOC code 31-1012);

(13) for night supervision staff, 20 percent of the median wage for home health aide (SOC code 31-1011); 20 percent of the median wage for personal and home health aide (SOC code 39-9021); 20 percent of the median wage for nursing aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(14) for respite staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing aides, orderlies, and attendants (SOC code 31-1012);

(15) for personal support staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing aides, orderlies, and attendants (SOC code 31-1012);

(16) for supervisory staff, the basic wage is $17.43 per hour with exception of the supervisor of behavior analyst and behavior specialists, which must be $30.75 per hour;

(17) for registered nurse, the basic wage is $30.82 per hour; and

(18) for licensed practical nurse, the basic wage is $18.64 per hour.

(b) Component values for residential support services are:

(1) supervisory span of control ratio: 11 percent;

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(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) general administrative support ratio: 13.25 percent;

(5) program-related expense ratio: 1.3 percent; and

(6) absence and utilization factor ratio: 3.9 percent.

(c) Component values for family foster care are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) general administrative support ratio: 3.3 percent;

(5) program-related expense ratio: 1.3 percent; and

(6) absence factor: 1.7 percent.

(d) Component values for day services for all services are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) program plan support ratio: 5.6 percent;

(5) client programming and support ratio: ten percent;

(6) general administrative support ratio: 13.25 percent;

(7) program-related expense ratio: 1.8 percent; and

(8) absence and utilization factor ratio: 3.9 percent.

(e) Component values for unit-based services with programming are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) program plan supports ratio: 3.1 percent;

(5) client programming and supports ratio: 8.6 percent;

(6) general administrative support ratio: 13.25 percent;

(7) program-related expense ratio: 6.1 percent; and

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(8) absence and utilization factor ratio: 3.9 percent.

(f) Component values for unit-based services without programming except respite are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) program plan support ratio: 3.1 percent;

(5) client programming and support ratio: 8.6 percent;

(6) general administrative support ratio: 13.25 percent;

(7) program-related expense ratio: 6.1 percent; and

(8) absence and utilization factor ratio: 3.9 percent.

(g) Component values for unit-based services without programming for respite are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) general administrative support ratio: 13.25 percent;

(5) program-related expense ratio: 6.1 percent; and

(6) absence and utilization factor ratio: 3.9 percent.

(h) On July 1, 2017, the commissioner shall update the base wage index in paragraph (a) based on the wage data by standard occupational code (SOC) from the Bureau of Labor Statistics available on December 31, 2016. The commissioner shall publish these updated values and load them into the rate management system. This adjustment occurs every five years. For adjustments in 2021 and beyond, the commissioner shall use the data available on December 31 of the calendar year five years prior.

(i) On July 1, 2017, the commissioner shall update the framework components in paragraphs (b) to (g); subdivision 6, clauses (8) and (9); and subdivision 7, clauses (16) and (17), for changes in the Consumer Price Index. The commissioner will adjust these values higher or lower by the percentage change in the Consumer Price Index-All Items, United States city average (CPI-U) from January 1, 2014, to January 1, 2017. The commissioner shall publish these updated values and load them into the rate management system. This adjustment occurs every five years. For adjustments in 2021 and beyond, the commissioner shall use the data available on January 1 of the calendar year four years prior and January 1 of the current calendar year.

Subd. 6. **Payments for residential support services.** (a) Payments for residential support services, as defined in sections 256B.092, subdivision 11, and 256B.49, subdivision 22, must be calculated as follows:

(1) determine the number of shared staffing and individual direct staff hours to meet a recipient's needs provided on site or through monitoring technology;

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(2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5. This is defined as the direct-care rate;

(3) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (2). This is defined as the customized direct-care rate;

(4) multiply the number of shared and individual direct staff hours provided on site or through monitoring technology and nursing hours by the appropriate staff wages in subdivision 5, paragraph (a), or the customized direct-care rate;

(5) multiply the number of shared and individual direct staff hours provided on site or through monitoring technology and nursing hours by the product of the supervision span of control ratio in subdivision 5, paragraph (b), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (16);

(6) combine the results of clauses (4) and (5), excluding any shared and individual direct staff hours provided through monitoring technology, and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (b), clause (2). This is defined as the direct staffing cost;

(7) for employee-related expenses, multiply the direct staffing cost, excluding any shared and individual direct staff hours provided through monitoring technology, by one plus the employee-related cost ratio in subdivision 5, paragraph (b), clause (3);

(8) for client programming and supports, the commissioner shall add $2,179; and

(9) for transportation, if provided, the commissioner shall add $1,680, or $3,000 if customized for adapted transport, based on the resident with the highest assessed need.

(b) The total rate must be calculated using the following steps:

(1) subtotal paragraph (a), clauses (7) to (9), and the direct staffing cost of any shared and individual direct staff hours provided through monitoring technology that was excluded in clause (7);

(2) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization ratio;

(3) divide the result of clause (1) by one minus the result of clause (2). This is the total payment amount; and

(4) adjust the result of clause (3) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

(c) The payment methodology for customized living, 24-hour customized living, and residential care services must be the customized living tool. Revisions to the customized living tool must be made to reflect the services and activities unique to disability-related recipient needs.

(d) The commissioner shall establish a Monitoring Technology Review Panel to annually review and approve the plans, safeguards, and rates that include residential direct care provided remotely through monitoring technology. Lead agencies shall submit individual service plans that include supervision using

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monitoring technology to the Monitoring Technology Review Panel for approval. Individual service plans that include supervision using monitoring technology as of December 31, 2013, shall be submitted to the Monitoring Technology Review Panel, but the plans are not subject to approval.

(e) For individuals enrolled prior to January 1, 2014, the days of service authorized must meet or exceed the days of service used to convert service agreements in effect on December 1, 2013, and must not result in a reduction in spending or service utilization due to conversion during the implementation period under section 256B.4913, subdivision 4a. If during the implementation period, an individual's historical rate, including adjustments required under section 256B.4913, subdivision 4a, paragraph (c), is equal to or greater than the rate determined in this subdivision, the number of days authorized for the individual is 365.

(f) The number of days authorized for all individuals enrolling after January 1, 2014, in residential services must include every day that services start and end.

Subd. 7. **Payments for day programs.** Payments for services with day programs including adult day care, day treatment and habilitation, prevocational services, and structured day services must be calculated as follows:

(1) determine the number of units of service and staffing ratio to meet a recipient's needs:

(i) the staffing ratios for the units of service provided to a recipient in a typical week must be averaged to determine an individual's staffing ratio; and

(ii) the commissioner, in consultation with service providers, shall develop a uniform staffing ratio worksheet to be used to determine staffing ratios under this subdivision;

(2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

(3) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (2). This is defined as the customized direct-care rate;

(4) multiply the number of day program direct staff hours and nursing hours by the appropriate staff wage in subdivision 5, paragraph (a), or the customized direct-care rate;

(5) multiply the number of day direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph (d), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (16);

(6) combine the results of clauses (4) and (5), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (d), clause (2). This is defined as the direct staffing rate;

(7) for program plan support, multiply the result of clause (6) by one plus the program plan support ratio in subdivision 5, paragraph (d), clause (4);

(8) for employee-related expenses, multiply the result of clause (7) by one plus the employee-related cost ratio in subdivision 5, paragraph (d), clause (3);

(9) for client programming and supports, multiply the result of clause (8) by one plus the client programming and support ratio in subdivision 5, paragraph (d), clause (5);

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(10) for program facility costs, add $19.30 per week with consideration of staffing ratios to meet individual needs;

(11) for adult day bath services, add $7.01 per 15 minute unit;

(12) this is the subtotal rate;

(13) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(14) divide the result of clause (12) by one minus the result of clause (13). This is the total payment amount;

(15) adjust the result of clause (14) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services;

(16) for transportation provided as part of day training and habilitation for an individual who does not require a lift, add:

(i) $10.50 for a trip between zero and ten miles for a nonshared ride in a vehicle without a lift, $8.83 for a shared ride in a vehicle without a lift, and $9.25 for a shared ride in a vehicle with a lift;

(ii) $15.75 for a trip between 11 and 20 miles for a nonshared ride in a vehicle without a lift, $10.58 for a shared ride in a vehicle without a lift, and $11.88 for a shared ride in a vehicle with a lift;

(iii) $25.75 for a trip between 21 and 50 miles for a nonshared ride in a vehicle without a lift, $13.92 for a shared ride in a vehicle without a lift, and $16.88 for a shared ride in a vehicle with a lift; or

(iv) $33.50 for a trip of 51 miles or more for a nonshared ride in a vehicle without a lift, $16.50 for a shared ride in a vehicle without a lift, and $20.75 for a shared ride in a vehicle with a lift;

(17) for transportation provided as part of day training and habilitation for an individual who does require a lift, add:

(i) $19.05 for a trip between zero and ten miles for a nonshared ride in a vehicle with a lift, and $15.05 for a shared ride in a vehicle with a lift;

(ii) $32.16 for a trip between 11 and 20 miles for a nonshared ride in a vehicle with a lift, and $28.16 for a shared ride in a vehicle with a lift;

(iii) $58.76 for a trip between 21 and 50 miles for a nonshared ride in a vehicle with a lift, and $58.76 for a shared ride in a vehicle with a lift; or

(iv) $80.93 for a trip of 51 miles or more for a nonshared ride in a vehicle with a lift, and $80.93 for a shared ride in a vehicle with a lift.

Subd. 8. **Payments for unit-based services with programming.** Payments for unit-based with program services, including behavior programming, housing access coordination, in-home family support, independent living skills training, hourly supported living services, and supported employment provided to an individual outside of any day or residential service plan must be calculated as follows, unless the services are authorized separately under subdivision 6 or 7:

(1) determine the number of units of service to meet a recipient's needs;

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(2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

(3) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (2). This is defined as the customized direct-care rate;

(4) multiply the number of direct staff hours by the appropriate staff wage in subdivision 5, paragraph (a), or the customized direct-care rate;

(5) multiply the number of direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph (e), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (16);

(6) combine the results of clauses (4) and (5), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (e), clause (2). This is defined as the direct staffing rate;

(7) for program plan support, multiply the result of clause (6) by one plus the program plan supports ratio in subdivision 5, paragraph (e), clause (4);

(8) for employee-related expenses, multiply the result of clause (7) by one plus the employee-related cost ratio in subdivision 5, paragraph (e), clause (3);

(9) for client programming and supports, multiply the result of clause (8) by one plus the client programming and supports ratio in subdivision 5, paragraph (e), clause (5);

(10) this is the subtotal rate;

(11) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(12) divide the result of clause (10) by one minus the result of clause (11). This is the total payment amount;

(13) for supported employment provided in a shared manner, divide the total payment amount in clause (12) by the number of service recipients, not to exceed three. For independent living skills training provided in a shared manner, divide the total payment amount in clause (12) by the number of service recipients, not to exceed two; and

(14) adjust the result of clause (13) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

Subd. 9. **Payments for unit-based services without programming.** Payments for unit-based without program services, including night supervision, personal support, respite, and companion care provided to an individual outside of any day or residential service plan must be calculated as follows unless the services are authorized separately under subdivision 6 or 7:

(1) for all services except respite, determine the number of units of service to meet a recipient's needs;

(2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;

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(3) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (2). This is defined as the customized direct care rate;

(4) multiply the number of direct staff hours by the appropriate staff wage in subdivision 5 or the customized direct care rate;

(5) multiply the number of direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph (f), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (16);

(6) combine the results of clauses (4) and (5), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (f), clause (2). This is defined as the direct staffing rate;

(7) for program plan support, multiply the result of clause (6) by one plus the program plan support ratio in subdivision 5, paragraph (f), clause (4);

(8) for employee-related expenses, multiply the result of clause (7) by one plus the employee-related cost ratio in subdivision 5, paragraph (f), clause (3);

(9) for client programming and supports, multiply the result of clause (8) by one plus the client programming and support ratio in subdivision 5, paragraph (f), clause (5);

(10) this is the subtotal rate;

(11) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(12) divide the result of clause (10) by one minus the result of clause (11). This is the total payment amount;

(13) for respite services, determine the number of day units of service to meet an individual's needs;

(14) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;

(15) for a recipient requiring deaf and hard-of-hearing customization under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (14). This is defined as the customized direct care rate;

(16) multiply the number of direct staff hours by the appropriate staff wage in subdivision 5, paragraph (a);

(17) multiply the number of direct staff hours by the product of the supervisory span of control ratio in subdivision 5, paragraph (g), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (16);

(18) combine the results of clauses (16) and (17), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (g), clause (2). This is defined as the direct staffing rate;

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(19) for employee-related expenses, multiply the result of clause (18) by one plus the employee-related cost ratio in subdivision 5, paragraph (g), clause (3);

(20) this is the subtotal rate;

(21) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(22) divide the result of clause (20) by one minus the result of clause (21). This is the total payment amount; and

(23) adjust the result of clauses (12) and (22) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

Subd. 10. **Updating payment values and additional information.** (a) From January 1, 2014, through December 31, 2017, the commissioner shall develop and implement uniform procedures to refine terms and adjust values used to calculate payment rates in this section.

(b) No later than July 1, 2014, the commissioner shall, within available resources, begin to conduct research and gather data and information from existing state systems or other outside sources on the following items:

(1) differences in the underlying cost to provide services and care across the state; and

(2) mileage, vehicle type, lift requirements, incidents of individual and shared rides, and units of transportation for all day services, which must be collected from providers using the rate management worksheet and entered into the rates management system; and

(3) the distinct underlying costs for services provided by a license holder certified under section 245D.33.

(c) Using a statistically valid set of rates management system data, the commissioner, in consultation with stakeholders, shall analyze for each service the average difference in the rate on December 31, 2013, and the framework rate at the individual, provider, lead agency, and state levels. The commissioner shall issue semiannual reports to the stakeholders on the difference in rates by service and by county during the banding period under section 256B.4913, subdivision 4a. The commissioner shall issue the first report by October 1, 2014.

(d) No later than July 1, 2014, the commissioner, in consultation with stakeholders, shall begin the review and evaluation of the following values already in subdivisions 6 to 9, or issues that impact all services, including, but not limited to:

(1) values for transportation rates for day services;

(2) values for transportation rates in residential services;

(3) values for services where monitoring technology replaces staff time;

(4) values for indirect services;

(5) values for nursing;

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(6) component values for independent living skills;

(7) component values for family foster care that reflect licensing requirements;

(8) adjustments to other components to replace the budget neutrality factor;

(9) remote monitoring technology for nonresidential services;

(10) values for basic and intensive services in residential services;

(11) values for the facility use rate in day services;

(12) values for workers' compensation as part of employee-related expenses;

(13) values for unemployment insurance as part of employee-related expenses;

(14) a component value to reflect costs for individuals with rates previously adjusted for the inclusion of group residential housing rate 3 costs, only for any individual enrolled as of December 31, 2013; and

(15) any changes in state or federal law with an impact on the underlying cost of providing home and community-based services.

(e) The commissioner shall report to the chairs and the ranking minority members of the legislative committees and divisions with jurisdiction over health and human services policy and finance with the information and data gathered under paragraphs (b) to (d) on the following dates:

(1) January 15, 2015, with preliminary results and data;

(2) January 15, 2016, with a status implementation update, and additional data and summary information;

(3) January 15, 2017, with the full report; and

(4) January 15, 2019, with another full report, and a full report once every four years thereafter.

(f) Based on the commissioner's evaluation of the information and data collected in paragraphs (b) to (d), the commissioner shall make recommendations to the legislature by January 15, 2015, to address any issues identified during the first year of implementation. After January 15, 2015, the commissioner may make recommendations to the legislature to address potential issues.

(g) The commissioner shall implement a regional adjustment factor to all rate calculations in subdivisions 6 to 9, effective no later than January 1, 2015. Prior to implementation, the commissioner shall consult with stakeholders on the methodology to calculate the adjustment.

(h) The commissioner shall provide a public notice via LISTSERV in October of each year beginning October 1, 2014, containing information detailing legislatively approved changes in:

(1) calculation values including derived wage rates and related employee and administrative factors;

(2) service utilization;

(3) county and tribal allocation changes; and

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(4) information on adjustments made to calculation values and the timing of those adjustments.

The information in this notice must be effective January 1 of the following year.

Subd. 11. **Payment implementation.** Upon implementation of the payment methodologies under this section, those payment rates supersede rates established in county contracts for recipients receiving waiver services under section 256B.092 or 256B.49.

Subd. 12. **Customization of rates for individuals.** (a) For persons determined to have higher needs based on being deaf or hard-of-hearing, the direct-care costs must be increased by an adjustment factor prior to calculating the rate under subdivisions 6, 7, 8, and 9. The customization rate with respect to deaf or hard-of-hearing persons shall be $2.50 per hour for waiver recipients who meet the respective criteria as determined by the commissioner.

(b) For the purposes of this section, "deaf and hard-of-hearing" means:

(1) the person has a developmental disability and an assessment score which indicates a hearing impairment that is severe or that the person has no useful hearing;

(2) the person has a developmental disability and an expressive communications score that indicates the person uses single signs or gestures, uses an augmentative communication aid, or does not have functional communication, or the person's expressive communications is unknown; and

(3) the person has a developmental disability and a communication score which indicates the person comprehends signs, gestures, and modeling prompts or does not comprehend verbal, visual, or gestural communication, or that the person's receptive communication score is unknown; or

(4) the person receives long-term care services and has an assessment score that indicates they hear only very loud sounds, have no useful hearing, or a determination cannot be made; and the person receives long-term care services and has an assessment that indicates the person communicates needs with sign language, symbol board, written messages, gestures, or an interpreter; communicates with inappropriate content, makes garbled sounds or displays echolalia, or does not communicate needs.

Subd. 13. **Transportation.** The commissioner shall require that the purchase of transportation services be cost-effective and be limited to market rates where the transportation mode is generally available and accessible.

Subd. 14. **Exceptions.** (a) In a format prescribed by the commissioner, lead agencies must identify individuals with exceptional needs that cannot be met under the disability waiver rate system. The commissioner shall use that information to evaluate and, if necessary, approve an alternative payment rate for those individuals.

(b) Lead agencies must submit exception requests to the state.

(c) An application for a rate exception may be submitted for the following criteria:

(1) an individual has service needs that cannot be met through additional units of service; or

(2) an individual's rate determined under subdivisions 6, 7, 8, and 9 results in an individual being discharged.

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(d) Exception requests must include the following information:

(1) the service needs required by each individual that are not accounted for in subdivisions 6, 7, 8, and 9;

(2) the service rate requested and the difference from the rate determined in subdivisions 6, 7, 8, and 9;

(3) a basis for the underlying costs used for the rate exception and any accompanying documentation;

(4) the duration of the rate exception; and

(5) any contingencies for approval.

(e) Approved rate exceptions shall be managed within lead agency allocations under sections 256B.092 and 256B.49.

(f) Individual disability waiver recipients may request that a lead agency submit an exception request. A lead agency that denies such a request shall notify the individual waiver recipient of its decision and the reasons for denying the request in writing no later than 30 days after the individual's request has been made.

(g) The commissioner shall determine whether to approve or deny an exception request no more than 30 days after receiving the request. If the commissioner denies the request, the commissioner shall notify the lead agency and the individual disability waiver recipient in writing of the reasons for the denial.

(h) The individual disability waiver recipient may appeal any denial of an exception request by either the lead agency or the commissioner, pursuant to sections 256.045 and 256.0451. When the denial of an exception request results in the proposed demission of a waiver recipient from a residential or day habilitation program, the commissioner shall issue a temporary stay of demission, when requested by the disability waiver recipient, consistent with the provisions of section 256.045, subdivisions 4a and 6, paragraph (c). The temporary stay shall remain in effect until the lead agency can provide an informed choice of appropriate, alternative services to the disability waiver.

(i) Providers may petition lead agencies to update values that were entered incorrectly or erroneously into the rate management system, based on past service level discussions and determination in subdivision 4, without applying for a rate exception.

Subd. 15. **County or tribal allocations.** (a) Upon implementation of the disability waiver rates management system on January 1, 2014, the commissioner shall establish a method of tracking and reporting the fiscal impact of the disability waiver rates management system on individual lead agencies.

(b) Beginning January 1, 2014, the commissioner shall make annual adjustments to lead agencies' home and community-based waivered service budget allocations to adjust for rate differences and the resulting impact on county allocations upon implementation of the disability waiver rates system.

(c) During the first two years of implementation under section 256B.4913, lead agencies exceeding their allocations under sections 256B.092 and 256B.49 shall only be held liable for spending in excess of their allocations after a reallocation of resources by the commissioner under paragraph (b). The commissioner shall reallocate resources under sections 256B.092, subdivision 12, and 256B.49, subdivision 11a. The commissioner shall notify lead agencies of this process by July 1, 2014.

Subd. 16. **Budget neutrality adjustments.** (a) The commissioner shall use the following adjustments to the rate generated by the framework to assure budget neutrality until the rate information is available

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to implement paragraph (b). The rate generated by the framework shall be multiplied by the appropriate factor, as designated below:

(1) for residential services: 1.003;

(2) for day services: 1.000;

(3) for unit-based services with programming: 0.941; and

(4) for unit-based services without programming: 0.796.

(b) Within 12 months of January 1, 2014, the commissioner shall compare estimated spending for all home and community-based waiver services under the new payment rates defined in subdivisions 6 to 9 with estimated spending for the same recipients and services under the rates in effect on July 1, 2013. This comparison must distinguish spending under each of subdivisions 6, 7, 8, and 9. The comparison must be based on actual recipients and services for one or more service months after the new rates have gone into effect. The commissioner shall consult with the commissioner of management and budget on this analysis to ensure budget neutrality. If estimated spending under the new rates for services under one or more subdivisions differs in this comparison by 0.3 percent or more, the commissioner shall assure aggregate budget neutrality across all service areas by adjusting the budget neutrality factor in paragraph (a) in each subdivision so that total estimated spending for each subdivision under the new rates matches estimated spending under the rates in effect on July 1, 2013.

History: *2013 c 108 art 13 s 12; 2014 c 312 art 27 s 62-69*

256B.492 HOME AND COMMUNITY-BASED SETTINGS FOR PEOPLE WITH DISABILITIES.

(a) Individuals receiving services under a home and community-based waiver under section 256B.092 or 256B.49 may receive services in the following settings:

(1) an individual's own home or family home;

(2) a licensed adult foster care or child foster care setting of up to five people or community residential setting of up to five people; and

(3) community living settings as defined in section 256B.49, subdivision 23, where individuals with disabilities may reside in all of the units in a building of four or fewer units, and who receive services under a home and community-based waiver occupy no more than the greater of four or 25 percent of the units in a multifamily building of more than four units, unless required by the Housing Opportunities for Persons with AIDS Program.

(b) The settings in paragraph (a) must not:

(1) be located in a building that is a publicly or privately operated facility that provides institutional treatment or custodial care;

(2) be located in a building on the grounds of or adjacent to a public or private institution;

(3) be a housing complex designed expressly around an individual's diagnosis or disability, unless required by the Housing Opportunities for Persons with AIDS Program;

(4) be segregated based on a disability, either physically or because of setting characteristics, from the larger community; and

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(5) have the qualities of an institution which include, but are not limited to: regimented meal and sleep times, limitations on visitors, and lack of privacy. Restrictions agreed to and documented in the person's individual service plan shall not result in a residence having the qualities of an institution as long as the restrictions for the person are not imposed upon others in the same residence and are the least restrictive alternative, imposed for the shortest possible time to meet the person's needs.

(c) The provisions of paragraphs (a) and (b) do not apply to any setting in which individuals receive services under a home and community-based waiver as of July 1, 2012, and the setting does not meet the criteria of this section.

(d) Notwithstanding paragraph (c), a program in Hennepin County established as part of a Hennepin County demonstration project is qualified for the exception allowed under paragraph (c).

(e) Notwithstanding paragraphs (a) and (b), a program in Hennepin County, located in the city of Golden Valley, within the city of Golden Valley's Highway 55 West redevelopment area, that is not a provider-owned or controlled home and community-based setting, and is scheduled to open by July 1, 2016, is exempt from the restrictions in paragraphs (a) and (b). If the program fails to comply with the Centers for Medicare and Medicaid Services rules for home and community-based settings, the exemption is void.

(f) The commissioner shall submit an amendment to the waiver plan no later than December 31, 2012.

History: *2012 c 247 art 4 s 37; 2013 c 63 s 16; 2013 c 108 art 7 s 43; 2014 c 291 art 8 s 10; 2014 c 312 art 27 s 70*

256B.493 ADULT FOSTER CARE PLANNED CLOSURE.

Subdivision 1. **Commissioner's duties; report.** The commissioner of human services shall solicit proposals for the conversion of services provided for persons with disabilities in settings licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, or community residential settings licensed under chapter 245D, to other types of community settings in conjunction with the closure of identified licensed adult foster care settings.

Subd. 2. **Planned closure process needs determination.** The commissioner shall announce and implement a program for planned closure of adult foster care homes. Planned closure shall be the preferred method for achieving necessary budgetary savings required by the licensed bed closure budget reduction in section 245A.03, subdivision 7, paragraph (c). If additional closures are required to achieve the necessary savings, the commissioner shall use the process and priorities in section 245A.03, subdivision 7, paragraph (c).

Subd. 3. **Application process.** (a) The commissioner shall establish a process for the application, review, and approval of proposals from license holders for the closure of adult foster care settings.

(b) When an application for a planned closure rate adjustment is submitted, the license holder shall provide written notification within five working days to the lead agencies responsible for authorizing the licensed services for the residents of the affected adult foster care settings. This notification shall be deemed confidential until the license holder has received approval of the application by the commissioner.

Subd. 4. **Review and approval process.** (a) To be considered for approval, an application must include:

(1) a description of the proposed closure plan, which must identify the home or homes and occupied beds for which a planned closure rate adjustment is requested;

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(2) the proposed timetable for any proposed closure, including the proposed dates for notification to residents and the affected lead agencies, commencement of closure, and completion of closure;

(3) the proposed relocation plan jointly developed by the counties of financial responsibility, the residents and their legal representatives, if any, who wish to continue to receive services from the provider, and the providers for current residents of any adult foster care home designated for closure; and

(4) documentation in a format approved by the commissioner that all the adult foster care homes receiving a planned closure rate adjustment under the plan have accepted joint and several liability for recovery of overpayments under section 256B.0641, subdivision 2, for the facilities designated for closure under this plan.

(b) In reviewing and approving closure proposals, the commissioner shall give first priority to proposals that:

(1) target counties and geographic areas which have:

(i) need for other types of services;

(ii) need for specialized services;

(iii) higher than average per capita use of foster care settings where the license holder does not reside; or

(iv) residents not living in the geographic area of their choice;

(2) demonstrate savings of medical assistance expenditures; and

(3) demonstrate that alternative services are based on the recipient's choice of provider and are consistent with federal law, state law, and federally approved waiver plans.

The commissioner shall also consider any information provided by service recipients, their legal representatives, family members, or the lead agency on the impact of the planned closure on the recipients and the services they need.

(c) The commissioner shall select proposals that best meet the criteria established in this subdivision for planned closure of adult foster care settings. The commissioner shall notify license holders of the selections approved by the commissioner.

(d) For each proposal approved by the commissioner, a contract must be established between the commissioner, the counties of financial responsibility, and the participating license holder.

Subd. 5. **Notification of approved proposal.** (a) Once the license holder receives notification from the commissioner that the proposal has been approved, the license holder shall provide written notification within five working days to:

(1) the lead agencies responsible for authorizing the licensed services for the residents of the affected adult foster care settings; and

(2) current and prospective residents, any legal representatives, and family members involved.

(b) This notification must occur at least 45 days prior to the implementation of the closure proposal.

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Subd. 6. **Adjustment to rates.** (a) For purposes of this section, the commissioner shall establish enhanced medical assistance payment rates under sections 256B.092 and 256B.49 to facilitate an orderly transition for persons with disabilities from adult foster care to other community-based settings.

(b) The enhanced payment rate shall be effective the day after the first resident has moved until the day the last resident has moved, not to exceed six months.

History: *2012 c 247 art 4 s 38; 2013 c 108 art 7 s 44; 2014 c 291 art 8 s 11*

256B.495 NURSING FACILITY RECEIVERSHIP FEES.

Subdivision 1. **Payment of receivership fees.** The commissioner in consultation with the commissioner of health may establish a receivership fee that exceeds a nursing facility payment rate when the commissioner of health determines a nursing facility is subject to the receivership provisions under section 144A.14 or 144A.15. In establishing the receivership fee, the commissioner must reduce the receiver's requested receivership fee by amounts that the commissioner determines are included in the nursing facility's payment rate and that can be used to cover part or all of the receivership fee. Amounts that can be used to reduce the receivership fee shall be determined by reallocating facility staff or costs that were formerly paid by the nursing facility before the receivership and are no longer required to be paid. The amounts may include any efficiency incentive, allowance, and other amounts not specifically required to be paid for expenditures of the nursing facility.

If the receivership fee cannot be covered by amounts in the nursing facility's payment rate, a receivership fee shall be set according to paragraphs (a) and (b) and payment shall be according to paragraphs (c) to (e).

(a) The receivership fee per diem shall be determined by dividing the annual receivership fee by the nursing facility's resident days from the most recent cost report for which the commissioner has established a payment rate or the estimated resident days in the projected receivership fee period.

(b) The receivership fee per diem shall be added to the nursing facility's payment rate.

(c) Notification of the payment rate increase must meet the requirements of section 256B.47, subdivision 2.

(d) The payment rate in paragraph (b) for a nursing facility shall be effective the first day of the month following the receiver's compliance with the notice conditions in paragraph (c).

(e) The commissioner may elect to make a lump-sum payment of a portion of the receivership fee to the receiver or managing agent. In this case, the commissioner and the receiver or managing agent shall agree to a repayment plan. Regardless of whether the commissioner makes a lump-sum payment under this paragraph, the provisions of paragraphs (a) to (d) and subdivision 2 also apply.

Subd. 1a. **Receivership payment rate adjustment.** Upon receiving a recommendation from the commissioner of health for a review of rates under section 144A.154, the commissioner may grant an adjustment to the nursing home's payment rate. The commissioner shall review the recommendation of the commissioner of health, together with the nursing home's cost report to determine whether or not the deficiency or need can be corrected or met by reallocating nursing home staff, costs, revenues, or other resources including any investments, efficiency incentives, or allowances. If the commissioner determines that the deficiency cannot be corrected or the need cannot be met, the commissioner shall determine the payment rate adjustment by dividing the additional annual costs established during the commissioner's review by the nursing home's actual resident days from the most recent desk-audited cost report.

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Subd. 2. **Deduction of additional receivership payments.** If the commissioner has established a receivership fee per diem for a nursing facility in receivership under subdivision 1 or a payment rate adjustment under subdivision 1a, the commissioner must deduct these receivership payments according to paragraphs (a) to (c).

(a) The total receivership fee payments shall be the receivership per diem plus the payment rate adjustment multiplied by the number of resident days for the period of the receivership. If actual resident days for the receivership period are not made available within two weeks of the commissioner's written request, the commissioner shall compute the resident days by prorating the facility's resident days based on the number of calendar days from each portion of the nursing facility's reporting years covered by the receivership period.

(b) The amount determined in paragraph (a) must be divided by the nursing facility's resident days for the reporting year in which the receivership period ends.

(c) The per diem amount in paragraph (b) shall be subtracted from the nursing facility's operating cost payment rate for the rate year following the reporting year in which the receivership period ends. This provision applies whether or not there is a sale or transfer of the nursing facility, unless the provisions of subdivision 5 apply.

Subd. 3. [Repealed, 1992 c 513 art 8 s 59]

Subd. 4. **Downsizing and closing nursing facilities.** (a) If the nursing facility is subject to a downsizing to closure process during the period of receivership, the commissioner may reestablish the nursing facility's payment rate. The payment rate shall be established based on the nursing facility's budgeted operating costs, the receivership property related costs, and the management fee costs for the receivership period divided by the facility's estimated resident days for the same period. The commissioner of health and the commissioner shall make every effort to first facilitate the transfer of private paying residents to alternate service sites prior to the effective date of the payment rate. The cost limits and the case mix provisions in the rate setting system shall not apply during the portion of the receivership period over which the nursing facility downsizes to closure.

(b) Any payment rate adjustment under this subdivision must meet the conditions in section 256B.47, subdivision 2, and shall remain in effect until the receivership ends, or until another date the commissioner sets.

Subd. 5. **Sale or transfer of a nursing facility in receivership after closure.** (a) Upon the subsequent sale or transfer of a nursing facility in receivership, the commissioner must recover any amounts paid through payment rate adjustments under subdivision 4 which exceed the normal cost of operating the nursing facility. Examples of costs in excess of the normal cost of operating the nursing facility include the managing agent's fee, directly identifiable costs of the managing agent, bonuses paid to employees for their continued employment during the downsizing to closure of the nursing facility, prereceivership expenditures paid by the receiver, additional professional services such as accountants, psychologists, and dietitians, and other similar costs incurred by the receiver to complete receivership. The buyer or transferee shall repay this amount to the commissioner within 60 days after the commissioner notifies the buyer or transferee of the obligation to repay. The buyer or transferee must also repay the private-pay resident the amount the private-pay resident paid through payment rate adjustment.

(b) If a nursing facility with payment rates subject to subdivision 4, paragraph (a), is later sold while the nursing facility is in receivership, the payment rates in effect prior to the receivership shall be the new

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owner's payment rates. Those payment rates shall continue to be in effect until the rate year following the reporting period ending on September 30 for the new owner. The reporting period shall, whenever possible, be at least five consecutive months. If the reporting period is less than five months but more than three months, the nursing facility's resident days for the last two months of the reporting period must be annualized over the reporting period for the purpose of computing the payment rate for the rate year following the reporting period.

History: *1989 c 282 art 3 s 83; 1990 c 568 art 3 s 77; 1992 c 513 art 7 s 115-119,136*

256B.50 APPEALS.

Subdivision 1. **Scope.** A provider may appeal from a determination of a payment rate established pursuant to this chapter and reimbursement rules of the commissioner if the appeal, if successful, would result in a change to the provider's payment rate or to the calculation of maximum charges to therapy vendors as provided by section 256B.433, subdivision 3. Appeals must be filed in accordance with procedures in this section. This section does not apply to a request from a resident or long-term care facility for reconsideration of the classification of a resident under section 144.0722.

Subd. 1a. **Definitions.** For the purposes of this section, the following terms have the meanings given.

(a) "Determination of a payment rate" means the process by which the commissioner establishes the payment rate paid to a provider pursuant to this chapter, including determinations made in desk audit, field audit, or pursuant to an amendment filed by the provider.

(b) "Provider" means a nursing facility as defined in section 256B.421, subdivision 7, or a facility as defined in section 256B.501, subdivision 1.

(c) "Reimbursement rules" means Minnesota Rules, parts 9510.0010 to 9510.0480, 9510.0500 to 9510.0890, and rules adopted by the commissioner pursuant to sections 256B.41 and 256B.501, subdivision 3.

Subd. 1b. **Filing an appeal.** To appeal, the provider shall file with the commissioner a written notice of appeal; the appeal must be postmarked or received by the commissioner within 60 days of the date the determination of the payment rate was mailed or personally received by a provider, whichever is earlier. The notice of appeal must specify each disputed item; the reason for the dispute; the total dollar amount in dispute for each separate disallowance, allocation, or adjustment of each cost item or part of a cost item; the computation that the provider believes is correct; the authority in statute or rule upon which the provider relies for each disputed item; the name and address of the person or firm with whom contacts may be made regarding the appeal; and other information required by the commissioner.

Subd. 1c. **Contested case procedures appeals review process.** (a) Effective for desk audit appeals for rate years beginning on or after July 1, 1997, and for field audit appeals filed on or after that date, the commissioner shall review appeals and issue a written appeal determination on each appealed item within one year of the due date of the appeal. Upon mutual agreement, the commissioner and the provider may extend the time for issuing a determination for a specified period. The commissioner shall notify the provider by first class mail of the appeal determination. The appeal determination takes effect 30 days following the date of issuance specified in the determination.

(b) In reviewing the appeal, the commissioner may request additional written or oral information from the provider. The provider has the right to present information by telephone, in writing, or in person

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concerning the appeal to the commissioner prior to the issuance of the appeal determination within six months of the date the appeal was received by the commissioner. Written requests for conferences must be submitted separately from the appeal letter. Statements made during the review process are not admissible in a contested case hearing absent an express stipulation by the parties to the contested case.

(c) For an appeal item on which the provider disagrees with the appeal determination, the provider may file with the commissioner a written demand for a contested case hearing to determine the proper resolution of specified appeal items. The demand must be postmarked or received by the commissioner within 30 days of the date of issuance specified in the determination. A contested case demand for an appeal item nullifies the written appeal determination issued by the commissioner for that appeal item. The commissioner shall refer any contested case demand to the Office of the Attorney General.

(d) A contested case hearing must be heard by an administrative law judge according to sections 14.48 to 14.56. In any proceeding under this section, the appealing party must demonstrate by a preponderance of the evidence that the determination of a payment rate is incorrect.

(e) Regardless of any rate appeal, the rate established must be the rate paid and must remain in effect until final resolution of the appeal or subsequent desk or field audit adjustment.

(f) To challenge the validity of rules established by the commissioner pursuant to this section and sections 256B.41, 256B.421, 256B.431, 256B.47, 256B.48, 256B.501, and 256B.502, a provider shall comply with section 14.44.

(g) The commissioner has discretion to issue to the provider a proposed resolution for specified appeal items upon a request from the provider filed separately from the notice of appeal. The proposed resolution is final upon written acceptance by the provider within 30 days of the date the proposed resolution was mailed to or personally received by the provider, whichever is earlier.

(h) The commissioner may use the procedures described in this subdivision to resolve appeals filed prior to July 1, 1997.

Subd. 1d. [Repealed, 1997 c 107 s 19]

Subd. 1e. **Attorney fees and costs.** (a) Notwithstanding section 15.472, paragraph (a), for an issue appealed under subdivision 1, the prevailing party in a contested case proceeding or, if appealed, in subsequent judicial review, must be awarded reasonable attorney 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.

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(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.

Subd. 1f. **Legal and related expenses.** Legal and related expenses for unresolved challenges to decisions by governmental agencies shall be separately identified and explained on the provider's cost report for each year in which the expenses are incurred. When the challenge is resolved in favor of the governmental agency, the provider shall notify the department of the extent to which its challenge was unsuccessful or the cost report filed for the reporting year in which the challenge was resolved. In addition, the provider shall inform the department of the years in which it claimed legal and related expenses and the amount of the expenses claimed in each year relating to the unsuccessful challenge. The department shall reduce the provider's medical assistance rate in the subsequent rate year by the total amount claimed by the provider for legal and related expenses incurred in an unsuccessful challenge to a decision by a governmental agency.

Subd. 1g. [Repealed, 1997 c 107 s 19]

Subd. 1h. [Repealed, 1997 c 107 s 19]

Subd. 2. [Repealed, 1997 c 107 s 19]

Subd. 3. [Repealed, 2000 c 449 s 15]

History: *1983 c 199 s 15; 1984 c 640 s 32; 1984 c 641 s 21; 1985 c 248 s 69; 1Sp1985 c 3 s 32; 1987 c 403 art 4 s 12; 1988 c 689 art 2 s 163-168; 1990 c 568 art 3 s 78,79; 1991 c 292 art 4 s 63; 1992 c 426*

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s 1; 1992 c 513 art 7 s 120,121,136; 1Sp1993 c 1 art 5 s 106-108; 1997 c 107 s 9-12; 1999 c 245 art 3 s 30; 2001 c 7 s 51

256B.501 RATES FOR COMMUNITY-BASED SERVICES FOR DISABLED.

Subdivision 1. **Definitions.** For the purposes of this section, the following terms have the meaning given them.

(a) "Commissioner" means the commissioner of human services.

(b) "Facility" means a facility licensed as a developmental disability residential facility under section 252.28, licensed as a supervised living facility under chapter 144, and certified as an intermediate care facility for persons with developmental disabilities. The term does not include a state regional treatment center.

(c) "Habilitation services" means health and social services directed toward increasing and maintaining the physical, intellectual, emotional, and social functioning of persons with developmental disabilities. Habilitation services include therapeutic activities, assistance, training, supervision, and monitoring in the areas of self-care, sensory and motor development, interpersonal skills, communication, socialization, reduction or elimination of maladaptive behavior, community living and mobility, health care, leisure and recreation, money management, and household chores.

(d) "Services during the day" means services or supports provided to a person that enables the person to be fully integrated into the community. Services during the day must include habilitation services, and may include a variety of supports to enable the person to exercise choices for community integration and inclusion activities. Services during the day may include, but are not limited to: supported work, support during community activities, community volunteer opportunities, adult day care, recreational activities, and other individualized integrated supports.

(e) "Waivered service" means home or community-based service authorized under United States Code, title 42, section 1396n(c), as amended through December 31, 1987, and defined in the Minnesota state plan for the provision of medical assistance services. Waivered services include, at a minimum, case management, family training and support, developmental training homes, supervised living arrangements, semi-independent living services, respite care, and training and habilitation services.

Subd. 2. **Authority.** The commissioner shall establish procedures and rules for determining rates for care of residents of intermediate care facilities for persons with developmental disabilities which qualify as providers of medical assistance and waivered services. The procedures shall specify the costs that are allowable for payment through medical assistance. The commissioner may use experts from outside the department in the establishment of the procedures.

Subd. 3. **Rates for intermediate care facilities.** The commissioner shall establish, by rule, procedures for determining rates for care of residents of intermediate care facilities for persons with developmental disabilities. In developing the procedures, the commissioner shall include:

(1) cost containment measures that assure efficient and prudent management of capital assets and operating cost increases which do not exceed increases in other sections of the economy;

(2) limits on the amounts of reimbursement for property and new facilities;

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(3) requirements to ensure that the accounting practices of the facilities conform to generally accepted accounting principles;

(4) incentives to reward accumulation of equity;

(5) rule revisions which:

(i) combine the program, maintenance, and administrative operating cost categories, and professional liability and real estate insurance expenses into one general operating cost category;

(ii) eliminate the maintenance and administrative operating cost category limits and account for disallowances under the rule existing on July 1, 1995, in the revised rule. If this provision is later invalidated, the total administrative cost disallowance shall be deducted from economical facility payments in item (iii);

(iii) establish an economical facility incentive that rewards facilities that provide all appropriate services in a cost-effective manner and penalizes reductions of either direct service wages or standardized hours of care per resident;

(iv) establish a best practices award system that is based on outcome measures and that rewards quality, innovation, cost-effectiveness, and staff retention;

(v) establish compensation limits for employees on the basis of full-time employment and the developmentally disabled client base of a provider group or facility. The commissioner may consider the inclusion of hold harmless provisions;

(vi) establish overall limits on a high cost facility's general operating costs. The commissioner shall consider groupings of facilities that account for a significant variation in cost. The commissioner may differentiate in the application of these limits between high and very high cost facilities. The limits, once established, shall be indexed for inflation and may be rebased by the commissioner;

(vii) utilize the client assessment information obtained from the application of the provisions in subdivision 3g for the revisions in items (iii), (iv), and (vi); and

(viii) develop cost allocation principles which are based on facility expenses; and

(6) appeals procedures that satisfy the requirements of section 256B.50.

Subd. 3a. [Repealed, 2014 c 262 art 4 s 9]

Subd. 3b. [Repealed, 2014 c 262 art 4 s 9]

Subd. 3c. **Forecasted index.** For rate years beginning on or after October 1, 1990, the commissioner shall index a facility's allowable operating costs in the program, maintenance, and administrative operating cost categories by using Data Resources, Inc., forecast for change in the Consumer Price Index-All Items (U.S. city average) (CPI-U). The commissioner shall use the indices as forecasted by Data Resources, Inc., in the first quarter of the calendar year in which the rate year begins. For fiscal years beginning after June 30, 1993, the commissioner shall not provide automatic inflation adjustments for intermediate care facilities for persons with developmental disabilities. The commissioner of management and budget shall include annual inflation adjustments in operating costs for intermediate care facilities for persons with developmental disabilities as a budget change request in each biennial detailed expenditure budget submitted to the legislature

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under section 16A.11. The commissioner shall use the Consumer Price Index-All Items (United States city average) (CPI-U) as forecasted by Data Resources, Inc., to take into account economic trends and conditions for changes in facility allowable historical general operating costs and limits. The forecasted index shall be established for allowable historical general operating costs as follows:

(1) the CPI-U forecasted index for allowable historical general operating costs shall be determined in the first quarter of the calendar year in which the rate year begins and shall be based on the 21-month period from the midpoint of the facility's reporting year to the midpoint of the rate year following the reporting year; and

(2) for rate years beginning on or after October 1, 1995, the CPI-U forecasted index for the overall operating cost limits and for the individual compensation limit shall be determined in the first quarter of the calendar year in which the rate year begins and shall be based on the 12-month period between the midpoints of the two reporting years preceding the rate year.

Subd. 3d. [Repealed, 1995 c 207 art 7 s 43]

Subd. 3e. [Repealed, 1995 c 207 art 7 s 43]

Subd. 3f. [Repealed, 1995 c 207 art 7 s 43]

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

Subd. 3h. [Repealed, 2014 c 262 art 4 s 9]

Subd. 3i. **Scope.** Subdivisions 3a to 3e and 3h do not apply to facilities whose payment rates are governed by Minnesota Rules, part 9553.0075.

Subd. 3j. [Repealed, 2014 c 262 art 4 s 9]

Subd. 3k. [Repealed, 2014 c 262 art 4 s 9]

Subd. 3l. [Repealed, 2014 c 262 art 4 s 9]

Subd. 3m. **Services during the day.** When establishing a rate for services during the day, the commissioner shall ensure that these services comply with active treatment requirements for persons residing in an ICF/DD as defined under federal regulations and shall ensure that services during the day for eligible persons are not provided by the person's residential service provider, unless the person or the person's legal representative is offered a choice of providers and agrees in writing to provision of services during the day by the residential service provider, consistent with the individual service plan. The individual service plan for individuals who choose to have their residential service provider provide their services during the day must describe how health, safety, protection, and habilitation needs will be met, including how frequent and regular contact with persons other than the residential service provider will occur. The individualized service plan must address the provision of services during the day outside the residence.

Subd. 4. **Waivered services.** In establishing rates for waivered services the commissioner shall consider the need for flexibility in the provision of those services to meet individual needs identified by the screening team.

Subd. 4a. **Inclusion of home care costs in waiver rates.** The commissioner shall adjust the limits of the established average daily reimbursement rates for waivered services to include the cost of home care

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services that may be provided to waivered services recipients. This adjustment must be used to maintain or increase services and shall not be used by county agencies for inflation increases for waivered services vendors. Home care services referenced in this section are those listed in section 256B.0651, subdivision 2. The average daily reimbursement rates established in accordance with the provisions of this subdivision apply only to the combined average, daily costs of waivered and home care services and do not change home care limitations under sections 256B.0651 to 256B.0654 and 256B.0659. Waivered services recipients receiving home care as of June 30, 1992, shall not have the amount of their services reduced as a result of this section.

Subd. 4b. **Waiver rates and group residential housing rates.** The average daily reimbursement rates established by the commissioner for waivered services shall be adjusted to include the additional costs of services eligible for waiver funding under title XIX of the Social Security Act and for which there is no group residential housing payment available as a result of the payment limitations set forth in section 256I.05, subdivision 10. The adjustment to the waiver rates shall be based on county reports of service costs that are no longer eligible for group residential housing payments. No adjustment shall be made for any amount of reported payments that prior to July 1, 1992, exceeded the group residential housing rate limits established in section 256I.05 and were reimbursed through county funds.

Subd. 4c. **Access to respite care.** Upon the request of a recipient receiving services under the community-based waiver for persons with developmental disabilities, or the recipient's legal representative, a county agency shall screen the recipient for appropriate and necessary services and shall place the recipient on and off the waiver as needed in order to allow the recipient access to short-term care as available in an intermediate care facility for persons with developmental disabilities.

Subd. 5. [Repealed, 1987 c 403 art 5 s 22]

Subd. 5a. **Changes to ICF/DD reimbursement.** The reimbursement rule changes in paragraphs (a) to (e) apply to Minnesota Rules, parts 9553.0010 to 9553.0080, and this section, and are effective for rate years beginning on or after October 1, 1993, unless otherwise specified.

(a) The maximum efficiency incentive shall be $1.50 per resident per day.

(b) If a facility's capital debt reduction allowance is greater than 50 cents per resident per day, that facility's capital debt reduction allowance in excess of 50 cents per resident day shall be reduced by 25 percent.

(c) Beginning with the biennial reporting year which begins January 1, 1993, a facility is no longer required to have a certified audit of its financial statements. The cost of a certified audit shall not be an allowable cost in that reporting year, nor in subsequent reporting years unless the facility submits its certified audited financial statements in the manner otherwise specified in this subdivision. A nursing facility which does not submit a certified audit must submit its working trial balance.

(d) In addition to the approved pension or profit-sharing plans allowed by the reimbursement rule, the commissioner shall allow those plans specified in Internal Revenue Code, sections 403(b) and 408(k).

(e) The commissioner shall allow as workers' compensation insurance costs under this section, the costs of workers' compensation coverage obtained under the following conditions:

(1) a plan approved by the commissioner of commerce as a Minnesota group or individual self-insurance plan as provided in sections 79A.03;

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(2) a plan in which:

(i) the facility, directly or indirectly, purchases workers' compensation coverage in compliance with section 176.181, subdivision 2, from an authorized insurance carrier;

(ii) a related organization to the facility reinsures the workers' compensation coverage purchased, directly or indirectly, by the facility; and

(iii) all of the conditions in clause (4) are met;

(3) a plan in which:

(i) the facility, directly or indirectly, purchases workers' compensation coverage in compliance with section 176.181, subdivision 2, from an authorized insurance carrier;

(ii) the insurance premium is calculated retrospectively, including a maximum premium limit, and paid using the paid loss retro method; and

(iii) all of the conditions in clause (4) are met;

(4) additional conditions are:

(i) the reserves for the plan are maintained in an account controlled and administered by a person which is not a related organization to the facility;

(ii) the reserves for the plan cannot be used, directly or indirectly, as collateral for debts incurred or other obligations of the facility or related organizations to the facility;

(iii) if the plan provides workers' compensation coverage for non-Minnesota facilities, the plan's cost methodology must be consistent among all facilities covered by the plan, and if reasonable, is allowed notwithstanding any reimbursement laws regarding cost allocation to the contrary;

(iv) central, affiliated, corporate, or nursing facility costs related to their administration of the plan are costs which must remain in the nursing facility's administrative cost category, and must not be allocated to other cost categories; and

(v) required security deposits, whether in the form of cash, investments, securities, assets, letters of credit, or in any other form are not allowable costs for purposes of establishing the facilities payment rate; and

(5) any costs allowed pursuant to clauses (1) to (3) are subject to the following requirements:

(i) if the facility is sold or otherwise ceases operations, the plan's reserves must be subject to an actuarially based settle up after 36 months from the date of sale or the date on which operations ceased. The facility's medical assistance portion of the total excess plan reserves must be paid to the state within 30 days following the date on which excess plan reserves are determined;

(ii) any distribution of excess plan reserves made to or withdrawals made by the facility or a related organization are applicable credits and must be used to reduce the facility's workers' compensation insurance costs in the reporting period in which a distribution or withdrawal is received; and

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(iii) if the plan is audited pursuant to the Medicare program, the facility must provide a copy of Medicare's final audit report, including attachments and exhibits, to the commissioner within 30 days of receipt by the facility or any related organization. The commissioner shall implement the audit findings associated with the plan upon receipt of Medicare's final audit report. The department's authority to implement the audit findings is independent of its authority to conduct a field audit.

Subd. 5b. [Repealed, 2014 c 262 art 4 s 9]

Subd. 5c. [Repealed, 1997 c 203 art 7 s 29]

Subd. 5d. **Adjustment for outreach crisis services.** An ICF/DD with crisis services developed under the authority of Laws 1992, chapter 513, article 9, section 40, shall have its operating cost per diem calculated according to paragraphs (a) and (b).

(a) Effective for services rendered from April 1, 1996, to September 30, 1996, and for rate years beginning on or after October 1, 1996, the maintenance limitation in Minnesota Rules, part 9553.0050, subpart 1, item A, subitem (2), shall be calculated to reflect capacity as of October 1, 1992. The maintenance limit shall be the per diem limitation otherwise in effect adjusted by the ratio of licensed capacity days as of October 1, 1992, divided by resident days in the reporting year ending December 31, 1993.

(b) Effective for rate years beginning on or after October 1, 1996, the operating cost per service unit, for purposes of the cost per service unit limit in subdivision 5b, paragraph (d), clauses (7) and (8), shall be calculated after excluding the costs directly identified to the provision of outreach crisis services and a four-bed crisis unit.

(c) The efficiency incentive paid to an ICF/DD shall not be increased as a result of this subdivision.

Subd. 5e. [Repealed, 2014 c 262 art 4 s 9]

Subd. 6. [Repealed, 1987 c 403 art 5 s 22]

Subd. 7. [Repealed, 1987 c 403 art 5 s 22]

Subd. 8. [Repealed, 2013 c 108 art 13 s 14]

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 developmental disabilities (ICF/DD) reimbursed under this section shall be paid by medical assistance in accordance with 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

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include a transition plan to aid the recipient in returning to the community-based ICF/DD 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/DD 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/DD receiving reimbursement under this section 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/DD 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/DD 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/DD is not meeting the terms of the cooperative service agreement under paragraph (f) or that the recipient will not return to the ICF/DD.

Subd. 9. [Repealed, 1987 c 403 art 5 s 22]

Subd. 10. **Rules.** To implement this section, the commissioner shall promulgate rules in accordance with chapter 14.

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

(b) For purposes of establishing payment rates under this subdivision and Minnesota Rules, parts 9553.0010 to 9553.0080, the term "newly constructed or newly established" means a facility (1) for which a need determination has been approved by the commissioner under sections 252.28 and 252.291; (2) whose program is newly licensed under Minnesota Rules, parts 9525.0215 to 9525.0355, and certified under Code of Federal Regulations, title 42, section 442.400, et seq.; and (3) that is part of a proposal that meets the requirements of section 252.291, subdivision 2, paragraph (a), clause (2). The term does not include a facility for which a need determination was granted solely for other reasons such as the relocation of a facility; a

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change in the facility's name, program, number of beds, type of beds, or ownership; or the sale of a facility, unless the relocation of a facility to one or more service sites is the result of a closure of a facility under section 252.292, in which case clause (3) shall not apply. The term does include a facility that converts more than 50 percent of its licensed beds from class A to class B residential or class B institutional to serve persons discharged from state regional treatment centers on or after May 1, 1990, in which case clause (3) does not apply.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 12. **ICF/DD salary adjustments.** Effective July 1, 1998, to September 30, 2000, the commissioner shall make available the appropriate salary adjustment cost per diem calculated in paragraphs (a) to (e) to the total operating cost payment rate of each facility subject to reimbursement under this section and Laws 1993, First Special Session chapter 1, article 4, section 11. The salary adjustment cost per diem must be determined as follows:

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

For the purpose of determining the amount of salary adjustment to be granted under this subdivision, the commissioner must use the reporting year ending December 31, 1996, as the base year for the salary adjustment per diem computation.

(b) For the rate period beginning July 1, 1998, each facility shall receive a salary adjustment cost per diem equal to its salary adjustment costs multiplied by 3.0 percent, and then divided by the facility's resident days.

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(c) A facility may apply for the salary adjustment per diem calculated under this subdivision. The application must be made to the commissioner and contain a plan by which the facility will distribute the salary adjustment to employees of the facility. For facilities in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative, 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 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.

(d) Additional costs incurred by facilities as a result of this salary adjustment are not allowable costs for purposes of the December 31, 1998, cost report.

(e) In order to apply for a salary adjustment, a facility reimbursed under Laws 1993, First Special Session chapter 1, article 4, section 11, must report the information referred to in paragraph (a) in the application, in the manner specified by the commissioner.

Subd. 13. **ICF/DD rate increases beginning October 1, 1999, and October 1, 2000.** (a) For the rate years beginning October 1, 1999, and October 1, 2000, the commissioner shall make available to each facility reimbursed under this section, section 256B.5011, and Laws 1993, First Special Session chapter 1, article 4, section 11, 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" means the facility's allowable program operating cost category employee training expenses and the facility's allowable salaries, payroll taxes, and fringe benefits. The term does not include these same salary-related costs for both administrative or central office employees.

For the purpose of determining the adjustment to be granted under this subdivision, the commissioner must use the most recent cost report that has been subject to desk audit.

(b) For the rate year beginning October 1, 1999, the commissioner shall make available a rate increase for compensation-related costs of 4.6 percent and a rate increase for all other operating costs of 3.2 percent.

(c) For the rate year beginning October 1, 2000, the commissioner shall make available:

(1) a rate increase for compensation-related costs of 6.6 percent, 45 percent of which shall be used to increase the per-hour pay rate of all employees except administrative and central office employees by an equal dollar amount and to pay associated costs for FICA, the Medicare tax, workers' compensation premiums, and federal and state unemployment insurance provided that this portion of the compensation-related increase shall be used only for wage increases implemented on or after October 1, 2000, and shall not be used for wage increases implemented prior to that date; and

(2) a rate increase for all other operating costs of two percent.

(d) For each facility, 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 facility's actual resident days.

(e) Any facility whose payment rates are governed by closure agreements, receivership agreements, or Minnesota Rules, part 9553.0075, are not eligible for an adjustment otherwise granted under this subdivision.

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(f) A 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 facility will distribute the compensation-related portion of the payment rate adjustment to employees of the facility. For facilities in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes the plan. For the second rate year, a negotiated agreement may constitute the plan only if the agreement is finalized after the date of enactment of all rate increases for the second rate year. The commissioner shall review the plan to ensure that the payment rate adjustment per diem is used as provided in this subdivision. To be eligible, a facility must submit its plan 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 October 1 of the year that the funds are available, the payment rate adjustment per diem shall be effective the same date as its plan.

(g) 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 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 telephone number provided by the commissioner and included in the approved plan.

Subd. 14. **Rate adjustment for ICF/DD in Cottonwood County.** The commissioner of health shall decertify three beds in an intermediate care facility for persons with developmental disabilities with 21 certified beds located in Cottonwood County. The total payment rate shall be $282.62 per bed, per day.

History: *1983 c 312 art 9 s 7; 1984 c 640 s 32; 1984 c 654 art 5 s 25,58; 1985 c 21 s 57; 1986 c 420 s 13; 1987 c 403 art 5 s 17-19; 1988 c 689 art 2 s 169-180; 1989 c 282 art 3 s 84-86; 1990 c 568 art 3 s 80-82; 1991 c 292 art 4 s 64-66; 1992 c 513 art 7 s 122; art 9 s 28,29; 1993 c 339 s 22; 1Sp1993 c 1 art 5 s 109-112; 1995 c 114 s 1; 1995 c 207 art 7 s 33-40; 1996 c 305 art 2 s 49,50; 1996 c 451 art 3 s 4-7; 1997 c 187 art 5 s 28; 1998 c 407 art 3 s 15; art 4 s 43; 1999 c 245 art 4 s 69; 2000 c 464 art 2 s 2; 2000 c 474 s 12; 2000 c 488 art 9 s 23,37; 2000 c 499 s 24,26; 2001 c 35 s 1; 2003 c 2 art 2 s 2; 1Sp2003 c 14 art 3 s 47,48; 2005 c 56 s 1; 2009 c 79 art 6 s 14; 2009 c 101 art 2 s 109; 2013 c 108 art 7 s 45; 2013 c 125 art 1 s 107; 2014 c 262 art 5 s 6*

256B.5011 ICF/DD 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 developmental disabilities, the commissioner shall index each facility's operating payment rate by an inflation factor as described in section 256B.5012. The commissioner of management and budget shall include annual inflation adjustments in operating costs for intermediate care facilities for persons with developmental disabilities 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) appropriate and necessary statistical information required by the commissioner;

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(3) annual aggregate facility financial information; and

(4) additional requirements for intermediate care facilities not meeting the standards set forth in the service contract.

(b) The commissioner of human services and the commissioner of health, in consultation with representatives from counties, advocacy organizations, and the provider community, shall review the home and community-based services standards under chapter 245D and the supervised living facility rule under Minnesota Rules, chapter 4665, to determine what provisions in Minnesota Rules, chapter 4665, may be waived by the commissioner of health for intermediate care facilities in order to enable facilities to implement the performance measures in their contract and provide quality services to residents without a duplication of or increase in regulatory requirements.

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

History: *1998 c 407 art 3 s 16; 1999 c 245 art 3 s 31,32; 2000 c 474 s 13; 2005 c 56 s 1; 2009 c 79 art 8 s 70; 2009 c 101 art 2 s 109; 2009 c 159 s 100; 2013 c 108 art 9 s 11; 2013 c 125 art 1 s 107*

256B.5012 ICF/DD PAYMENT SYSTEM IMPLEMENTATION.

Subdivision 1. **Total payment rate.** The total payment rate effective October 1, 2000, for existing ICF/DD 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 management and budget'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.

(c) Effective July 1, 2001, the operating payment rate shall be adjusted for the increases in the Department of Health licensing fees that were authorized in section 144.122.

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/DD facilities. Facilities with a modified property payment rate effective September 30, 2000, which is below the minimum property rate shall receive an

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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.

Subd. 4. **ICF/DD rate increases beginning July 1, 2001, and July 1, 2002.** (a) For the rate years beginning July 1, 2001, and July 1, 2002, the commissioner shall make available to each facility reimbursed under this section an adjustment to the total operating payment rate of 3.5 percent. Of this adjustment, two-thirds must be used as provided under paragraph (b) and one-third must be used for operating costs.

(b) The adjustment under this paragraph must be used to increase the wages and benefits and pay associated costs of all employees except administrative and central office employees, provided that this increase must be used only for wage and benefit increases implemented on or after the first day of the rate year and must not be used for increases implemented prior to that date.

(c) For each facility, the commissioner shall make available an adjustment using the percentage specified in paragraph (a) multiplied by the total payment rate, excluding the property-related payment rate, in effect on the preceding June 30. The total payment rate shall include the adjustment provided in section 256B.501, subdivision 12.

(d) A facility whose payment rates are governed by closure agreements, receivership agreements, or Minnesota Rules, part 9553.0075, is not eligible for an adjustment otherwise granted under this subdivision.

(e) A facility may apply for the payment rate adjustment provided under paragraph (b). The application must be made to the commissioner and contain a plan by which the facility will distribute the adjustment in paragraph (b) to employees of the facility. For facilities in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes the plan. A negotiated agreement may constitute the plan only if the agreement is finalized after the date of enactment of all rate increases for the rate year. The commissioner shall review the plan to ensure that the payment rate adjustment per diem is used as provided in this subdivision. To be eligible, a facility must submit its plan by March 31, 2002, and March 31, 2003, respectively. If a facility's plan is effective for its employees after the first day of the applicable rate year that the funds are available, the payment rate adjustment per diem is effective the same date as its plan.

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

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Subd. 5. **Rate increase effective June 1, 2003.** For rate periods beginning on or after June 1, 2003, the commissioner shall increase the total operating payment rate for each facility reimbursed under this section by $3 per day. The increase shall not be subject to any annual percentage increase.

Subd. 6. **ICF/DD rate increases October 1, 2005, and October 1, 2006.** (a) For the rate periods beginning October 1, 2005, and October 1, 2006, the commissioner shall make available to each facility reimbursed under this section an adjustment to the total operating payment rate of 2.2553 percent.

(b) 75 percent of the money resulting from the rate adjustment under paragraph (a) must be used to increase wages and benefits and pay associated costs for employees, except for administrative and central office employees. 75 percent of the money received by a facility as a result of the rate adjustment provided in paragraph (a) must be used only for wage, benefit, and staff increases implemented on or after the effective date of the rate increase each year, and must not be used for increases implemented prior to that date. The wage adjustment eligible employees may receive may vary based on merit, seniority, or other factors determined by the provider.

(c) For each facility, the commissioner shall make available an adjustment, based on occupied beds, using the percentage specified in paragraph (a) multiplied by the total payment rate, including variable rate but excluding the property-related payment rate, in effect on the preceding day. The total payment rate shall include the adjustment provided in section 256B.501, subdivision 12.

(d) A facility whose payment rates are governed by closure agreements or receivership agreements is not eligible for an adjustment otherwise granted under this subdivision.

(e) A facility may apply for the portion of the payment rate adjustment provided under paragraph (a) for employee wages and benefits and associated costs. The application must be made to the commissioner and contain a plan by which the facility will distribute the funds according to paragraph (b). For facilities in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes the plan. A negotiated agreement may constitute the plan only if the agreement is finalized after the date of enactment of all rate increases for the rate year. The commissioner shall review the plan to ensure that the payment rate adjustment per diem is used as provided in this subdivision. To be eligible, a facility must submit its plan by March 31, 2006, and December 31, 2006, respectively. If a facility's plan is effective for its employees after the first day of the applicable rate period that the funds are available, the payment rate adjustment per diem is effective the same date as its plan.

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

Subd. 7. **ICF/DD rate increases effective October 1, 2007, and October 1, 2008.** (a) For the rate year beginning October 1, 2007, the commissioner shall make available to each facility reimbursed under this section operating payment rate adjustments equal to 2.0 percent of the operating payment rates in effect on September 30, 2007. For the rate year beginning October 1, 2008, the commissioner shall make available to each facility reimbursed under this section operating payment rate adjustments equal to 2.0 percent of the operating payment rates in effect on September 30, 2008. For each facility, the commissioner shall

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make available an adjustment, based on occupied beds, using the percentage specified in this paragraph multiplied by the total payment rate, including the variable rate but excluding the property-related payment rate, in effect on the preceding day. The total payment rate shall include the adjustment provided in section 256B.501, subdivision 12. A facility whose payment rates are governed by closure agreements or receivership agreements is not eligible for an adjustment otherwise granted under this subdivision.

(b) Seventy-five percent of the money resulting from the rate adjustments under paragraph (a) must be used for increases in compensation-related costs for employees directly employed by the facility on or after the effective date of the rate adjustments, except:

(1) the administrator;

(2) persons employed in the central office of a corporation that has an ownership interest in the facility or exercises control over the facility; and

(3) persons paid by the facility under a management contract.

(c) Two-thirds of the money available under paragraph (b) must be used for wage increases for all employees directly employed by the facility on or after the effective date of the rate adjustments, except those listed in paragraph (b), clauses (1) to (3). The wage adjustment that employees receive under this paragraph must be paid as an equal hourly percentage wage increase for all eligible employees. All wage increases under this paragraph must be effective on the same date. Only costs associated with the portion of the equal hourly percentage wage increase that goes to all employees shall qualify under this paragraph. Costs associated with wage increases in excess of the amount of the equal hourly percentage wage increase provided to all employees shall be allowed only for meeting the requirements in paragraph (b). This paragraph shall not apply to employees covered by a collective bargaining agreement.

(d) The commissioner shall allow as compensation-related costs all costs for:

(1) wages and salaries;

(2) FICA taxes, Medicare taxes, state and federal unemployment taxes, and workers' compensation;

(3) the employer's share of health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, and pensions; and

(4) other benefits provided, subject to the approval of the commissioner.

(e) The portion of the rate adjustments under paragraph (a) that is not subject to the requirements in paragraphs (b) and (c) shall be provided to facilities effective October 1 of each year.

(f) Facilities may apply for the portion of the rate adjustments under paragraph (a) that is subject to the requirements in paragraphs (b) and (c). The application must be submitted to the commissioner within six months of the effective date of the rate adjustments, and the facility must provide additional information required by the commissioner within nine months of the effective date of the rate adjustments. The commissioner must respond to all applications within three weeks of receipt. The commissioner may waive the deadlines in this paragraph under extraordinary circumstances, to be determined at the sole discretion of the commissioner. The application must contain:

(1) an estimate of the amounts of money that must be used as specified in paragraphs (b) and (c);

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(2) a detailed distribution plan specifying the allowable compensation-related and wage increases the facility will implement to use the funds available in clause (1);

(3) a description of how the facility will notify eligible employees of the contents of the approved application, which must provide for giving each eligible employee a copy of the approved application, excluding the information required in clause (1), or posting a copy of the approved application, excluding the information required in clause (1), for a period of at least six weeks in an area of the facility to which all eligible employees have access; and

(4) instructions for employees who believe they have not received the compensation-related or wage increases specified in clause (2), as approved by the commissioner, and which must include a mailing address, e-mail address, and the telephone number that may be used by the employee to contact the commissioner or the commissioner's representative.

(g) The commissioner shall ensure that cost increases in distribution plans under paragraph (f), clause (2), that may be included in approved applications, comply with requirements in clauses (1) to (4):

(1) costs to be incurred during the applicable rate year resulting from wage and salary increases effective after October 1, 2006, and prior to the first day of the facility's payroll period that includes October 1 of each year shall be allowed if they were not used in the prior year's application and they meet the requirements of paragraphs (b) and (c);

(2) a portion of the costs resulting from tenure-related wage or salary increases may be considered to be allowable wage increases, according to formulas that the commissioner shall provide, where employee retention is above the average statewide rate of retention of direct care employees;

(3) the annualized amount of increases in costs for the employer's share of health and dental insurance, life insurance, disability insurance, and workers' compensation shall be allowable compensation-related increases if they are effective on or after April 1 of the year in which the rate adjustments are effective and prior to April 1 of the following year; and

(4) for facilities in which employees are represented by an exclusive bargaining representative, the commissioner shall approve the application only upon receipt of a letter of acceptance of the distribution plan, as regards members of the bargaining unit, signed by the exclusive bargaining agent and dated after May 25, 2007. Upon receipt of the letter of acceptance, the commissioner shall deem all requirements of this section as having been met in regard to the members of the bargaining unit.

(h) The commissioner shall review applications received under paragraph (f) and shall provide the portion of the rate adjustments under paragraphs (b) and (c) if the requirements of this subdivision have been met. The rate adjustments shall be effective October 1 of each year. Notwithstanding paragraph (a), if the approved application distributes less money than is available, the amount of the rate adjustment shall be reduced so that the amount of money made available is equal to the amount to be distributed.

Subd. 8. **ICF/DD rate decreases effective July 1, 2009.** Effective July 1, 2009, the commissioner shall decrease each facility reimbursed under this section operating payment adjustments equal to 2.58 percent of the operating payment rates in effect on June 30, 2009. For each facility, the commissioner shall implement the rate reduction, based on occupied beds, using the percentage specified in this subdivision multiplied by the total payment rate, including the variable rate but excluding the property-related payment rate, in effect on the preceding date. The total rate reduction shall include the adjustment provided in subdivision 7.

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Subd. 9. **ICF/DD rate increase effective July 1, 2011; Clearwater County.** Effective July 1, 2011, the commissioner shall increase the daily rate to $138.23 at an intermediate care facility for the developmentally disabled located in Clearwater County and classified as a class A facility with 15 beds.

Subd. 10. **ICF/DD rate decrease effective July 1, 2011; exception for Clearwater County.** For each facility reimbursed under this section, except for a facility located in Clearwater County and classified as a class A facility with 15 beds, the commissioner shall decrease operating payment rates equal to 0.095 percent of the operating payment rates in effect on June 30, 2011. For each facility, the commissioner shall apply the rate reduction, based on occupied beds, using the percentage specified in this subdivision multiplied by the total payment rate, including the variable rate but excluding the property-related payment rate, in effect on the preceding date. The total rate reduction shall include the adjustment provided in section 256B.501, subdivision 12.

Subd. 11. **ICF/DD rate decrease effective July 1, 2011.** For each facility reimbursed under this section, the commissioner shall decrease operating payments equal to 1.5 percent of the operating payment rates in effect on June 30, 2011. For each facility, the commissioner shall apply the rate reduction, based on occupied beds, using the percentage specified in this subdivision multiplied by the total payment rate, including the variable rate but excluding the property-related payment rate, in effect on the preceding date. The total rate reduction shall include the adjustment provided in section 256B.501, subdivision 12.

Subd. 12. **ICF/DD rate increase effective July 1, 2013.** For each facility reimbursed under this section, the commissioner shall increase operating payments equal to one-half percent of the operating payment rates in effect on June 30, 2013. For each facility, the commissioner shall apply the rate increase, based on occupied beds, using the percentage specified in this subdivision multiplied by the total payment rate, including the variable rate but excluding the property-related payment rate, in effect on the preceding date. The total rate increase shall include the adjustment provided in section 256B.501, subdivision 12.

Subd. 13. [Repealed, 2013 c 108 art 7 s 64]

Subd. 14. **Rate increase effective June 1, 2013.** For rate periods beginning on or after June 1, 2013, the commissioner shall increase the total operating payment rate for each facility reimbursed under this section by $7.81 per day. The increase shall not be subject to any annual percentage increase.

Subd. 15. **ICF/DD rate increases effective April 1, 2014.** (a) Notwithstanding subdivision 12, for each facility reimbursed under this section, for the rate period beginning April 1, 2014, the commissioner shall increase operating payments equal to one percent of the operating payment rates in effect on March 31, 2014.

(b) For each facility, the commissioner shall apply the rate increase based on occupied beds, using the percentage specified in this subdivision multiplied by the total payment rate, including the variable rate, but excluding the property-related payment rate in effect on the preceding date. The total rate increase shall include the adjustment provided in section 256B.501, subdivision 12.

Subd. 16. **ICF/DD rate increases effective July 1, 2014.** (a) For the rate period beginning July 1, 2014, the commissioner shall increase operating payments for each facility reimbursed under this section equal to five percent of the operating payment rates in effect on June 30, 2014.

(b) For each facility, the commissioner shall apply the rate increase based on occupied beds, using the percentage specified in this subdivision multiplied by the total payment rate, including the variable rate but excluding the property-related payment rate in effect on June 30, 2014. The total rate increase shall include the adjustment provided in section 256B.501, subdivision 12.

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(c) To receive the rate increase under paragraph (a), each facility reimbursed under this section must submit to the commissioner documentation that identifies a quality improvement project that the facility will implement by June 30, 2015. Documentation must be provided in a format specified by the commissioner. Projects must:

(1) improve the quality of life of intermediate care facility residents in a meaningful way;

(2) improve the quality of services in a measurable way; or

(3) deliver good quality service more efficiently while using the savings to enhance services for the participants served.

(d) For a facility that fails to submit the documentation described in paragraph (c) by a date or in a format specified by the commissioner, the commissioner shall reduce the facility's rate by one percent effective January 1, 2015.

(e) Facilities that receive a rate increase under this subdivision shall use 80 percent of the additional revenue to increase compensation-related costs for employees directly employed by the facility on or after July 1, 2014, except:

(1) persons employed in the central office of a corporation or entity that has an ownership interest in the facility or exercises control over the facility; and

(2) persons paid by the facility under a management contract.

This requirement is subject to audit by the commissioner.

(f) Compensation-related costs include:

(1) wages and salaries;

(2) the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, and mileage reimbursement;

(3) the employer's share of health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, pensions, and contributions to employee retirement accounts; and

(4) other benefits provided and workforce needs, including the recruiting and training of employees as specified in the distribution plan required under paragraph (i).

(g) For public employees under a collective bargaining agreement, the increase for wages and benefits is available and pay rates must be increased only to the extent that the increases comply with laws governing public employees' collective bargaining. Money received by a facility under paragraph (e) for pay increases for public employees must be used only for pay increases implemented between July 1, 2014, and August 1, 2014.

(h) For a facility that has employees that are represented by an exclusive bargaining representative, the provider shall obtain a letter of acceptance of the distribution plan required under paragraph (i), in regard to the members of the bargaining unit, signed by the exclusive bargaining agent. Upon receipt of the letter of acceptance, the facility shall be deemed to have met all the requirements of this subdivision in regard to the members of the bargaining unit. Upon request, the facility shall produce the letter of acceptance for the commissioner.

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(i) A facility that receives a rate adjustment under paragraph (a) that is subject to paragraph (e) shall prepare, and upon request submit to the commissioner, a distribution plan that specifies the amount of money the facility expects to receive that is subject to the requirements of paragraph (e), including how that money will be distributed to increase compensation for employees. The commissioner may recover funds from a facility that fails to comply with this requirement.

(j) By January 1, 2015, the facility shall post the distribution plan required under paragraph (i) for a period of at least six weeks in an area of the facility's operation to which all eligible employees have access and shall provide instructions for employees who do not believe they have received the wage and other compensation-related increases specified in the distribution plan. The instructions must include a mailing address, e-mail address, and telephone number that an employee may use to contact the commissioner or the commissioner's representative.

History: *1999 c 245 art 3 s 33; 1Sp2001 c 9 art 5 s 30; 2002 c 375 art 2 s 42; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 2 s 38; 1Sp2005 c 4 art 7 s 45; 2006 c 282 art 20 s 27; 2007 c 147 art 7 s 59; 2008 c 363 art 15 s 13; 2009 c 79 art 8 s 71; 2009 c 101 art 2 s 109; 2009 c 159 s 101,102; 2010 c 382 s 50; 1Sp2011 c 9 art 7 s 42-46; 2012 c 247 art 4 s 39; 2013 c 108 art 7 s 46,47; 2013 c 125 art 1 s 107; 2014 c 312 art 27 s 71*

256B.5013 PAYMENT RATE ADJUSTMENTS.

Subdivision 1. **Variable rate adjustments.** (a) For rate years beginning on or after October 1, 2000, when there is a documented increase in the needs of a current ICF/DD recipient, the county of financial responsibility may recommend a variable rate to enable the facility to meet the individual's increased needs. Variable rate adjustments made under this subdivision replace payments for persons with special needs under section 256B.501, subdivision 8, and payments for persons with special needs for crisis intervention services under section 256B.501, subdivision 8a. Effective July 1, 2003, facilities with a base rate above the 50th percentile of the statewide average reimbursement rate for a Class A facility or Class B facility, whichever matches the facility licensure, are not eligible for a variable rate adjustment. Variable rate adjustments may not exceed a 12-month period, except when approved for purposes established in paragraph (b), clause (1). Variable rate adjustments approved solely on the basis of changes on a developmental disabilities screening document will end June 30, 2002.

(b) A variable rate may be recommended by the county of financial responsibility for increased needs in the following situations:

(1) a need for resources due to an individual's full or partial retirement from participation in a day training and habilitation service when the individual: (i) has reached the age of 65 or has a change in health condition that makes it difficult for the person to participate in day training and habilitation services over an extended period of time because it is medically contraindicated; and (ii) has expressed a desire for change through the developmental disability screening process under section 256B.092;

(2) a need for additional resources for intensive short-term programming which is necessary prior to an individual's discharge to a less restrictive, more integrated setting;

(3) a demonstrated medical need that significantly impacts the type or amount of services needed by the individual; or

(4) a demonstrated behavioral need that significantly impacts the type or amount of services needed by the individual.

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(c) The county of financial responsibility must justify the purpose, the projected length of time, and the additional funding needed for the facility to meet the needs of the individual.

(d) The facility shall provide an annual report to the county case manager on the use of the variable rate funds and the status of the individual on whose behalf the funds were approved. The county case manager will forward the facility's report with a recommendation to the commissioner to approve or disapprove a continuation of the variable rate.

(e) Funds made available through the variable rate process that are not used by the facility to meet the needs of the individual for whom they were approved shall be returned to the state.

Subd. 2. [Repealed, 2009 c 159 s 112]

Subd. 3. [Repealed, 2009 c 159 s 112]

Subd. 4. [Repealed, 1Sp2003 c 14 art 3 s 60]

Subd. 5. [Repealed, 2009 c 159 s 112]

Subd. 6. **Commissioner's responsibilities.** The commissioner shall:

(1) make a determination to approve, deny, or modify a request for a variable rate adjustment within 30 days of the receipt of the completed application;

(2) notify the ICF/DD facility and county case manager of the duration and conditions of variable rate adjustment approvals; and

(3) modify MMIS II service agreements to reimburse ICF/DD facilities for approved variable rates.

Subd. 7. **Rate adjustments; short-term admissions; crisis or specialized medical care.** Beginning July 1, 2003, the commissioner may designate up to 25 beds in ICF/DD facilities statewide for short-term admissions due to crisis care needs or care for medically fragile individuals. The commissioner shall adjust the monthly facility rate to provide payment for vacancies in designated short-term beds by an amount equal to the rate for each recipient residing in a designated bed for up to 15 days per bed per month. The commissioner may designate short-term beds in ICF/DD facilities based on the short-term care needs of a region or county as provided in section 252.28. Nothing in this section shall be construed as limiting payments for short-term admissions of eligible recipients to an ICF/DD that is not designated for short-term admissions for crisis or specialized medical care under this subdivision and does not receive a temporary rate adjustment.

History: *1999 c 245 art 3 s 34; 2000 c 474 s 14-16; 2001 c 203 s 13; 2002 c 220 art 14 s 14-18; 2002 c 374 art 10 s 7; 1Sp2003 c 14 art 3 s 49; 2005 c 56 s 1; 2009 c 159 s 103,104; 2013 c 125 art 1 s 107*

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;

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(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 OTHER SERVICES COSTS.

Subdivision 1. **Day training and habilitation services.** Day 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 252.41 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 ICF/DD facility total payment rate.

Subd. 2. **Services during the day.** Services during the day, as defined in section 256B.501, but excluding day training and habilitation services, shall be paid as a pass-through payment no later than January 1, 2004. The commissioner shall establish rates for these services, other than day training and habilitation services, at levels that do not exceed 75 percent of a recipient's day training and habilitation service costs prior to the service change.

When establishing a rate for these services, the commissioner shall also consider an individual recipient's needs as identified in the individualized service plan and the person's need for active treatment as defined under federal regulations. The pass-through payments for services during the day shall be paid separately by the commissioner and shall not be included in the computation of the ICF/DD facility total payment rate.

History: *1999 c 245 art 3 s 36; 1Sp2003 c 14 art 3 s 50; 2013 c 125 art 1 s 107; 2014 c 275 art 1 s 65*

256B.5016 [Repealed, 2014 c 262 art 4 s 9]

NOTE: Subdivision 1 was also amended by Laws 2014, chapter 291, article 10, section 4, to read as follows:

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

256B.502 RULES.

The commissioners of health and human services shall promulgate rules necessary to implement Laws 1983, chapter 199.

History: *1983 c 199 s 16; 1984 c 640 s 32; 1984 c 654 art 5 s 58; 1996 c 305 art 2 s 51; 1997 c 187 art 5 s 29*

256B.503 [Repealed, 2014 c 262 art 4 s 9]

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256B.504 [Repealed, 1995 c 248 art 2 s 8]

256B.51 NURSING HOMES; COST OF HOME CARE.

Subdivision 1. **In-home care for elderly; experimental program.** To determine the effectiveness of home care in providing or arranging for the care and services which would normally be provided in a nursing home, the commissioner of human services may establish an experimental program to subsidize a limited number of eligible agencies or households which agree to carry out a planned program of in-home care for an elderly or physically disabled person. The household or agency to provide the services shall be selected by the person who will receive the services.

This program shall be limited to agencies or households caring for persons who are physically disabled or 60 years of age or older, and who otherwise would require and be eligible for placement in a nursing home.

Subd. 2. **Grants.** Grants to eligible agencies or households shall be determined by the commissioner of human services. In determining the grants, the commissioner shall consider the cost of diagnostic assessments, homemaker services, specialized equipment, visiting nurses' or other pertinent therapists' costs, social services, day program costs, and related transportation expenses, not to exceed 50 percent of the average medical assistance reimbursement rate for nursing homes in the region of the person's residence.

Subd. 3. **Care plan required.** An individual care plan for the person shall be established and agreed upon by the person or agency providing the care, the person or agency receiving the subsidy, the person receiving the care, and the appropriate local welfare agency. The plan shall be periodically evaluated to determine the person's progress.

History: *1976 c 312 s 2; 1984 c 654 art 5 s 58*

256B.53 [Repealed, 2014 c 262 art 2 s 18]

256B.55 MS 2006 [Expired]

256B.56 [Repealed, 1996 c 310 s 1]

256B.57 [Repealed, 1996 c 310 s 1]

256B.58 [Repealed, 1996 c 310 s 1]

256B.59 [Repealed, 1996 c 310 s 1]

256B.60 [Repealed, 1996 c 310 s 1]

256B.61 [Repealed, 1996 c 310 s 1]

256B.62 [Repealed, 1996 c 310 s 1]

256B.63 [Repealed, 1996 c 310 s 1]

256B.64 ATTENDANTS TO VENTILATOR-DEPENDENT RECIPIENTS.

A ventilator-dependent recipient of medical assistance who has been receiving the services of a home care nurse or personal care assistant in the recipient's home may continue to have a home care nurse or personal care assistant present upon admission to a hospital licensed under chapter 144. The personal care

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assistant or home care nurse shall perform only the services of communicator or interpreter for the ventilator-dependent patient during a transition period of up to 120 hours to assure adequate training of the hospital staff to communicate with the patient and to understand the unique comfort, safety, and personal care needs of the patient. The personal care assistant or home care nurse may offer nonbinding advice to the health care professionals in charge of the ventilator-dependent patient's care and treatment on matters pertaining to the comfort and safety of the patient. Within 36 hours of the end of the 120-hour transition period, an assessment may be made by the ventilator-dependent recipient, the attending physician, and the hospital staff caring for the recipient. If the persons making the assessment determine that additional communicator or interpreter services are medically necessary, the hospital must contact the commissioner 24 hours prior to the end of the 120-hour transition period and submit the assessment information to the commissioner. The commissioner shall review the request and determine if it is medically necessary to continue the interpreter services or if the hospital staff has had sufficient opportunity to adequately determine the needs of the patient. The commissioner shall determine if continued service is necessary and appropriate and whether or not payments shall continue. The commissioner may not authorize services beyond the limits of the available appropriations for this section. The commissioner may adopt rules necessary to implement this section. Reimbursement under this section must be at the payment rate and in a manner consistent with the payment rate and manner used in reimbursing these providers for home care services for the ventilator-dependent recipient under the medical assistance program.

History: *1988 c 689 art 2 s 181; 1991 c 292 art 7 s 20; 2014 c 291 art 9 s 5*

256B.69 PREPAID HEALTH PLANS.

Subdivision 1. **Purpose.** The commissioner of human services shall establish a medical assistance demonstration project to determine whether prepayment combined with better management of health care services is an effective mechanism to ensure that all eligible individuals receive necessary health care in a coordinated fashion while containing costs. For the purposes of this project, waiver of certain statutory provisions is necessary in accordance with this section.

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

(a) "Commissioner" means the commissioner of human services. For the remainder of this section, the commissioner's responsibilities for methods and policies for implementing the project will be proposed by the project advisory committees and approved by the commissioner.

(b) "Demonstration provider" means a health maintenance organization, community integrated service network, or accountable provider network authorized and operating under chapter 62D, 62N, or 62T that participates in the demonstration project according to criteria, standards, methods, and other requirements established for the project and approved by the commissioner. For purposes of this section, a county board, or group of county boards operating under a joint powers agreement, is considered a demonstration provider if the county or group of county boards meets the requirements of section 256B.692.

(c) "Eligible individuals" means those persons eligible for medical assistance benefits as defined in sections 256B.055, 256B.056, and 256B.06.

(d) "Limitation of choice" means suspending freedom of choice while allowing eligible individuals to choose among the demonstration providers.

Subd. 3. **Geographic area.** The commissioner shall designate the geographic areas in which eligible individuals may be included in the medical assistance prepayment programs.

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Subd. 3a. **County authority.** (a) The commissioner, when implementing the 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 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.

(b) At the option of the county board, the board may develop contract requirements related to the achievement of local public health goals to meet the health needs of medical assistance enrollees. These requirements must be reasonably related to the performance of health plan functions and within the scope of the medical assistance benefit set. 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 program in that county at initial implementation of the program in that county and at the time of contract renewal. The county board may participate in the enforcement of the contract provisions related to local public health goals.

(c) For counties in which a prepaid medical assistance program has not been established, the commissioner shall not implement that program if a county board submits an acceptable and timely preliminary and final proposal under section 256B.692, until county-based purchasing is no longer operational in that county. For counties in which a prepaid medical assistance program is 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 a preliminary and final proposal according to that subdivision. The commissioner is not required to terminate contracts that begin on or after September 1, 1997, according to section 256B.692 until two years have elapsed from the date of initial enrollment.

(d) In the event that a county board or a single entity representing a group of county boards and the commissioner cannot reach agreement regarding: (i) the selection of participating health plans in that county; (ii) contract requirements; or (iii) implementation and enforcement of county requirements including provisions regarding local public health goals, the commissioner shall resolve all disputes after taking into account the recommendations of a three-person mediation panel. The panel shall be composed of one designee of the president of the association of Minnesota counties, one designee of the commissioner of human services, and one person selected jointly by the designee of the commissioner of human services and the designee of

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the Association of Minnesota Counties. Within a reasonable period of time before the hearing, the panelists must be provided all documents and information relevant to the mediation. The parties to the mediation must be given 30 days' notice of a hearing before the mediation panel.

(e) If a county which elects to implement county-based purchasing ceases to implement county-based purchasing, it is prohibited from assuming the responsibility of county-based purchasing for a period of five years from the date it discontinues purchasing.

(f) The commissioner shall not require that contractual disputes between county-based purchasing entities and the commissioner be mediated by a panel that includes a representative of the Minnesota Council of Health Plans.

(g) At the request of a county-purchasing entity, the commissioner shall adopt a contract reprocurement or renewal schedule under which all counties included in the entity's service area are reprocured or renewed at the same time.

(h) The commissioner shall provide a written report under section 3.195 to the chairs of the legislative committees having jurisdiction over human services in the senate and the house of representatives describing in detail the activities undertaken by the commissioner to ensure full compliance with this section. The report must also provide an explanation for any decisions of the commissioner not to accept the recommendations of a county or group of counties required to be consulted under this section. The report must be provided at least 30 days prior to the effective date of a new or renewed prepaid or managed care contract in a county.

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.

Subd. 4. **Limitation of choice.** (a) The commissioner shall develop criteria to determine when limitation of choice may be implemented in the experimental counties. The criteria shall ensure that all eligible individuals in the county have continuing access to the full range of medical assistance services as specified in subdivision 6.

(b) The commissioner shall exempt the following persons from participation in the project, in addition to those who do not meet the criteria for limitation of choice:

(1) persons eligible for medical assistance according to section 256B.055, subdivision 1;

(2) persons eligible for medical assistance due to blindness or disability as determined by the Social Security Administration or the state medical review team, unless:

(i) they are 65 years of age or older; or

(ii) they reside in Itasca County or they reside in a county in which the commissioner conducts a pilot project under a waiver granted pursuant to section 1115 of the Social Security Act;

(3) recipients who currently have private coverage through a health maintenance organization;

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(4) recipients who are eligible for medical assistance by spending down excess income for medical expenses other than the nursing facility per diem expense;

(5) recipients who receive benefits under the Refugee Assistance Program, established under United States Code, title 8, section 1522(e);

(6) children who are both determined to be severely emotionally disturbed and receiving case management services according to section 256B.0625, subdivision 20, except children who are eligible for and who decline enrollment in an approved preferred integrated network under section 245.4682;

(7) adults who are both determined to be seriously and persistently mentally ill and received case management services according to section 256B.0625, subdivision 20;

(8) persons eligible for medical assistance according to section 256B.057, subdivision 10; and

(9) persons with access to cost-effective employer-sponsored private health insurance or persons enrolled in a non-Medicare individual health plan determined to be cost-effective according to section 256B.0625, subdivision 15.

Children under age 21 who are in foster placement may enroll in the project on an elective basis. Individuals excluded under clauses (1), (6), and (7) may choose to enroll on an elective basis. The commissioner may enroll recipients in the prepaid medical assistance program for seniors who are (1) age 65 and over, and (2) eligible for medical assistance by spending down excess income.

(c) The commissioner may allow persons with a one-month spenddown who are otherwise eligible to enroll to voluntarily enroll or remain enrolled, if they elect to prepay their monthly spenddown to the state.

(d) The commissioner may require those individuals to enroll in the prepaid medical assistance program who otherwise would have been excluded under paragraph (b), clauses (1), (3), and (8), and under Minnesota Rules, part 9500.1452, subpart 2, items H, K, and L.

(e) Before limitation of choice is implemented, eligible individuals shall be notified and after notification, shall be allowed to choose only among demonstration providers. The commissioner may assign an individual with private coverage through a health maintenance organization, to the same health maintenance organization for medical assistance coverage, if the health maintenance organization is under contract for medical assistance in the individual's county of residence. After initially choosing a provider, the recipient is allowed to change that choice only at specified times as allowed by the commissioner. If a demonstration provider ends participation in the project for any reason, a recipient enrolled with that provider must select a new provider but may change providers without cause once more within the first 60 days after enrollment with the second provider.

(f) An infant born to a woman who is eligible for and receiving medical assistance and who is enrolled in the prepaid medical assistance program shall be retroactively enrolled to the month of birth in the same managed care plan as the mother once the child is enrolled in medical assistance unless the child is determined to be excluded from enrollment in a prepaid plan under this section.

Subd. 4a. [Repealed, 1996 c 451 art 5 s 39]

Subd. 4b. **Individualized education program and individualized family service plan services.** The commissioner shall amend the federal waiver allowing the state to separate out individualized education program and individualized family service plan services for children enrolled in the prepaid medical as-

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sistance program and the MinnesotaCare program. Medical assistance coverage of eligible individualized education program 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. Local school districts shall bill the commissioner for these services, and claims shall be paid on a fee-for-service basis.

Subd. 5. **Prospective per capita payment.** The commissioner shall establish the method and amount of payments for services. The commissioner shall annually contract with demonstration providers to provide services consistent with these established methods and amounts for payment.

If allowed by the commissioner, a demonstration provider may contract with an insurer, health care provider, nonprofit health service plan corporation, or the commissioner, to provide insurance or similar protection against the cost of care provided by the demonstration provider or to provide coverage against the risks incurred by demonstration providers under this section. The recipients enrolled with a demonstration provider are a permissible group under group insurance laws and chapter 62C, the Nonprofit Health Service Plan Corporations Act. Under this type of contract, the insurer or corporation may make benefit payments to a demonstration provider for services rendered or to be rendered to a recipient. Any insurer or nonprofit health service plan corporation licensed to do business in this state is authorized to provide this insurance or similar protection.

Payments to providers participating in the project are exempt from the requirements of sections 256.966 and 256B.03, subdivision 2. The commissioner shall complete development of capitation rates for payments before delivery of services under this section is begun. The commissioner shall contract with an independent actuary to establish prepayment rates.

Beginning July 1, 2004, the commissioner may include payments for elderly waiver services and 180 days of nursing home care in capitation payments for the prepaid medical assistance program for recipients age 65 and older.

Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section and section 256L.12 shall be entered into or renewed on a calendar year basis. The commissioner may issue separate contracts with requirements specific to services to medical assistance recipients age 65 and older.

(b) A prepaid health plan providing covered health services for eligible persons pursuant to chapters 256B and 256L is responsible for complying with the terms of its contract with the commissioner. Requirements applicable to managed care programs under chapters 256B and 256L established after the effective date of a contract with the commissioner take effect when the contract is next issued or renewed.

(c) The commissioner shall withhold five percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. Clinical or utilization performance targets and their related criteria must consider evidence-based research and reasonable interventions when available or applicable to the populations served, and must be developed with input from external clinical experts and stakeholders, including managed care plans, county-based purchasing plans, and providers. The managed care or county-based purchasing plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the admin-

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istrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, including characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July of the following year if performance targets in the contract are achieved. The commissioner may exclude special demonstration projects under subdivision 23.

(d) The commissioner shall require that managed care plans use the assessment and authorization processes, forms, timelines, standards, documentation, and data reporting requirements, protocols, billing processes, and policies consistent with medical assistance fee-for-service or the Department of Human Services contract requirements consistent with medical assistance fee-for-service or the Department of Human Services contract requirements for all personal care assistance services under section 256B.0659.

(e) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the health plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. For 2012, the reduction shall be based on the health plan's utilization in 2009. To earn the return of the withhold each subsequent year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than ten percent of the plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, compared to the previous measurement year until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph shall continue for each consecutive contract period until the plan's emergency room utilization rate for state health care program enrollees is reduced by 25 percent of the plan's emergency room utilization rate for medical assistance and MinnesotaCare enrollees for calendar year 2009. Hospitals shall cooperate with the health plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

(f) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than five percent of the plan's hospital admission rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, compared to the previous calendar year until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

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The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that this reduction in the hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph shall continue until there is a 25 percent reduction in the hospital admission rate compared to the hospital admission rates in calendar year 2011, as determined by the commissioner. The hospital admissions in this performance target do not include the admissions applicable to the subsequent hospital admission performance target under paragraph (g). Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

(g) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization admission rates for subsequent hospitalizations within 30 days of a previous hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of the subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, of no less than five percent compared to the previous calendar year until the final performance target is reached.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a qualifying reduction in the subsequent hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph must continue for each consecutive contract period until the plan's subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that must be returned to the hospitals if the performance target is achieved.

(h) Effective for services rendered on or after January 1, 2013, through December 31, 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(i) Effective for services rendered on or after January 1, 2014, the commissioner shall withhold three percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(j) A managed care plan or a county-based purchasing plan under section 256B.692 may include as admitted assets under section 62D.044 any amount withheld under this section that is reasonably expected to be returned.

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(k) Contracts between the commissioner and a prepaid health plan are exempt from the set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph (a), and 7.

(l) The return of the withhold under paragraphs (h) and (i) is not subject to the requirements of paragraph (c).

Subd. 5b. **Prospective reimbursement rates.** (a) For prepaid medical assistance program contract rates set by the commissioner under subdivision 5, capitation rates for nonmetropolitan counties shall on a weighted average be no less than 87 percent of the capitation rates for metropolitan counties, excluding Hennepin County. The commissioner shall make a pro rata adjustment in capitation rates paid to counties other than nonmetropolitan counties in order to make this provision budget neutral. The commissioner, in consultation with a health care actuary, shall evaluate the regional rate relationships based on actual health plan costs for Minnesota health care programs. The commissioner may establish, based on the actuary's recommendation, new rate regions that recognize metropolitan areas outside of the seven-county metropolitan area.

(b) This subdivision shall not affect the nongeographically based risk adjusted rates established under section 62Q.03, subdivision 5a.

Subd. 5c. **Medical education and research fund.** (a) The commissioner of human services shall transfer each year to the medical education and research fund established under section 62J.692, an amount specified in this subdivision. The commissioner shall calculate the following:

(1) an amount equal to the reduction in the prepaid medical assistance payments as specified in this clause. After January 1, 2002, the county medical assistance capitation base rate prior to plan specific adjustments is reduced 6.3 percent for Hennepin County, two percent for the remaining metropolitan counties, and 1.6 percent for nonmetropolitan Minnesota counties. Nursing facility and elderly waiver payments and demonstration project payments operating under subdivision 23 are excluded from this reduction. The amount calculated under this clause shall not be adjusted for periods already paid due to subsequent changes to the capitation payments;

(2) beginning July 1, 2003, $4,314,000 from the capitation rates paid under this section;

(3) beginning July 1, 2002, an additional $12,700,000 from the capitation rates paid under this section; and

(4) beginning July 1, 2003, an additional $4,700,000 from the capitation rates paid under this section.

(b) This subdivision shall be effective upon approval of a federal waiver which allows federal financial participation in the medical education and research fund. The amount specified under paragraph (a), clauses (1) to (4), shall not exceed the total amount transferred for fiscal year 2009. Any excess shall first reduce the amounts specified under paragraph (a), clauses (2) to (4). Any excess following this reduction shall proportionally reduce the amount specified under paragraph (a), clause (1).

(c) Beginning September 1, 2011, of the amount in paragraph (a), the commissioner shall transfer $21,714,000 each fiscal year to the medical education and research fund.

(d) Beginning September 1, 2011, of the amount in paragraph (a), following the transfer under paragraph (c), the commissioner shall transfer to the medical education research fund $23,936,000 in fiscal years 2012 and 2013 and $49,552,000 in fiscal year 2014 and thereafter.

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Subd. 5d. **Modification of payment dates effective January 1, 2001.** Effective for services rendered on or after January 1, 2001, capitation payments under this section for services provided in the month of June shall be made no earlier than the first day after the month of service.

Subd. 5e. [Repealed, 2014 c 262 art 2 s 18]

Subd. 5f. **Capitation rates.** (a) Beginning July 1, 2002, the capitation rates paid under this section are increased by $12,700,000 per year. Beginning July 1, 2003, the capitation rates paid under this section are increased by $4,700,000 per year.

(b) Beginning July 1, 2009, the capitation rates paid under this section are increased each year by the lesser of $21,714,000 or an amount equal to the difference between the estimated value of the reductions described in subdivision 5c, paragraph (a), clause (1), and the amount of the limit described in subdivision 5c, paragraph (b).

Subd. 5g. **Payment for covered services.** For services rendered on or after January 1, 2003, the total payment made to managed care plans for providing covered services under the medical assistance program is reduced by .5 percent from their current statutory rates. This provision excludes payments for nursing home services, home and community-based waivers, payments to demonstration projects for persons with disabilities, and mental health services added as covered benefits after December 31, 2007.

Subd. 5h. **Payment reduction.** In addition to the reduction in subdivision 5g, the total payment made to managed care plans under the medical assistance program is reduced 1.0 percent for services provided on or after October 1, 2003, and an additional 1.0 percent for services provided on or after January 1, 2004. This provision excludes payments for nursing home services, home and community-based waivers, payments to demonstration projects for persons with disabilities, and mental health services added as covered benefits after December 31, 2007.

Subd. 5i. **Administrative expenses.** (a) Managed care plan and county-based purchasing plan administrative costs for a prepaid health plan provided under this section or section 256B.692 must not exceed by more than five percent that prepaid health plan's or county-based purchasing plan's actual calculated administrative spending for the previous calendar year as a percentage of total revenue. The penalty for exceeding this limit must be the amount of administrative spending in excess of 105 percent of the actual calculated amount. The commissioner may waive this penalty if the excess administrative spending is the result of unexpected shifts in enrollment or member needs or new program requirements.

(b) The following expenses are not allowable administrative expenses for rate-setting purposes under this section:

(1) charitable contributions made by the managed care plan or the county-based purchasing plan;

(2) any portion of an individual's compensation in excess of $200,000 paid by the managed care plan or county-based purchasing plan;

(3) any penalties or fines assessed against the managed care plan or county-based purchasing plan; and

(4) any indirect marketing or advertising expenses of the managed care plan or county-based purchasing plan.

For the purposes of this subdivision, compensation includes salaries, bonuses and incentives, other reportable compensation on an IRS 990 form, retirement and other deferred compensation, and nontaxable benefits.

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Subd. 5j. **Treatment of investment earnings.** Capitation rates shall treat investment income and interest earnings as income to the same extent that investment-related expenses are treated as administrative expenditures.

Subd. 5k. **Actuarial soundness.** (a) Rates paid to managed care plans and county-based purchasing plans shall satisfy requirements for actuarial soundness. In order to comply with this subdivision, the rates must:

(1) be neither inadequate nor excessive;

(2) satisfy federal requirements;

(3) in the case of contracts with incentive arrangements, not exceed 105 percent of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement;

(4) be developed in accordance with generally accepted actuarial principles and practices;

(5) be appropriate for the populations to be covered and the services to be furnished under the contract; and

(6) be certified as meeting the requirements of federal regulations by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

(b) Each year within 30 days of the establishment of plan rates the commissioner shall report to the chairs and ranking minority members of the senate Health and Human Services Budget Division and the house of representatives Health Care and Human Services Finance Division to certify how each of these conditions have been met by the new payment rates.

Subd. 6. **Service delivery.** (a) Each demonstration provider shall be responsible for the health care coordination for eligible individuals. Demonstration providers:

(1) shall authorize and arrange for the provision of all needed health services including but not limited to the full range of services listed in sections 256B.02, subdivision 8, and 256B.0625 in order to ensure appropriate health care is delivered to enrollees. Notwithstanding section 256B.0621, demonstration providers that provide nursing home and community-based services under this section shall provide relocation service coordination to enrolled persons age 65 and over;

(2) shall accept the prospective, per capita payment from the commissioner in return for the provision of comprehensive and coordinated health care services for eligible individuals enrolled in the program;

(3) may contract with other health care and social service practitioners to provide services to enrollees; and

(4) shall institute recipient grievance procedures according to the method established by the project, utilizing applicable requirements of chapter 62D. Disputes not resolved through this process shall be appealable to the commissioner as provided in subdivision 11.

(b) Demonstration providers must comply with the standards for claims settlement under section 72A.201, subdivisions 4, 5, 7, and 8, when contracting with other health care and social service practitioners

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to provide services to enrollees. A demonstration provider must pay a clean claim, as defined in Code of Federal Regulations, title 42, section 447.45(b), within 30 business days of the date of acceptance of the claim.

Subd. 6a. **Nursing home services.** (a) Notwithstanding Minnesota Rules, part 9500.1457, subpart 1, item B, up to 180 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. The commissioner may develop a schedule to phase in implementation of the 180-day provision.

(b) For individuals enrolled in the Minnesota senior health options project or in other demonstrations authorized under subdivision 23, nursing facility services shall be covered according to the terms and conditions of the federal agreement governing that demonstration project.

(c) For individuals enrolled in demonstrations authorized under subdivision 23, services in an intermediate care facility for persons with developmental disabilities shall be covered according to the terms and conditions of the federal agreement governing the 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 enrolled in demonstrations 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.

(c) The commissioner of human services shall issue requests for proposals for collaborative service models between counties and managed care organizations to integrate the home and community-based elderly waiver services and additional nursing home services into the prepaid medical assistance program.

(d) Notwithstanding Minnesota Rules, part 9500.1457, subpart 1, item C, elderly waiver services shall be covered statewide under the prepaid medical assistance program for all individuals who are eligible according to section 256B.0915. The commissioner may develop a schedule to phase in implementation of these waiver services, including collaborative service models under paragraph (c). The commissioner shall phase in implementation beginning with those counties participating under section 256B.692, and those counties where a viable collaborative service model has been developed. In consultation with counties and all managed care organizations that have expressed an interest in participating in collaborative service models, the commissioner shall evaluate the models. The commissioner shall consider the evaluation in selecting the most appropriate models for statewide implementation.

Subd. 6c. [Repealed, 2014 c 262 art 2 s 18]

Subd. 6d. **Prescription drugs.** The commissioner may exclude or modify coverage for prescription drugs from the prepaid managed care contracts entered into under this section in order to increase savings to the state by collecting additional prescription drug rebates. The contracts must maintain incentives for the managed care plan to manage drug costs and utilization and may require that the managed care plans maintain an open drug formulary. In order to manage drug costs and utilization, the contracts may authorize the managed care plans to use preferred drug lists and prior authorization. This subdivision is contingent

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on federal approval of the managed care contract changes and the collection of additional prescription drug rebates.

Subd. 7. **Enrollee benefits.** All eligible individuals enrolled by demonstration providers shall receive all needed health care services as defined in subdivision 6.

All enrolled individuals have the right to appeal if necessary services are not being authorized as defined in subdivision 11.

Subd. 8. **Preadmission screening waiver.** Except as applicable to the project's operation, the provisions of sections 256.975 and 256B.0911 are waived for the purposes of this section for recipients enrolled with demonstration providers or in the prepaid medical assistance program for seniors.

Subd. 9. **Reporting.** (a) Each demonstration provider shall submit information as required by the commissioner, including data required for assessing client satisfaction, quality of care, cost, and utilization of services for purposes of project evaluation. The commissioner shall also develop methods of data reporting and collection in order to provide aggregate enrollee information on encounters and outcomes to determine access and quality assurance. Required information shall be specified before the commissioner contracts with a demonstration provider.

(b) Aggregate nonpersonally identifiable health plan encounter data, aggregate spending data for major categories of service as reported to the commissioners of health and commerce under section 62D.08, subdivision 3, clause (a), and criteria for service authorization and service use are public data that the commissioner shall make available and use in public reports. The commissioner shall require each health plan and county-based purchasing plan to provide:

(1) encounter data for each service provided, using standard codes and unit of service definitions set by the commissioner, in a form that the commissioner can report by age, eligibility groups, and health plan; and

(2) criteria, written policies, and procedures required to be disclosed under section 62M.10, subdivision 7, and Code of Federal Regulations, title 42, part 438.210 (b)(1), used for each type of service for which authorization is required.

(c) Each demonstration provider shall report to the commissioner on the extent to which providers employed by or under contract with the demonstration provider use patient-centered decision-making tools or procedures designed to engage patients early in the decision-making process and the steps taken by the demonstration provider to encourage their use.

Subd. 9a. **Administrative expense reporting.** Within the limit of available appropriations, the commissioner shall work with the commissioner of health to identify and collect data on administrative spending for state health care programs reported to the commissioner of health by managed care plans under section 62D.08 and county-based purchasing plans under section 256B.692, provided that such data are consistent with guidelines and standards for administrative spending that are developed by the commissioner of health, and reported to the legislature under Laws 2008, chapter 364, section 12. Data provided to the commissioner under this subdivision are nonpublic data as defined under section 13.02.

Subd. 9b. [Repealed, 1Sp2011 c 9 art 6 s 97]

Subd. 9c. **Managed care financial reporting.** (a) The commissioner shall collect detailed data regarding financials, provider payments, provider rate methodologies, and other data as determined by the commissioner. The commissioner, in consultation with the commissioners of health and commerce, and

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in consultation with managed care plans and county-based purchasing plans, shall set uniform criteria, definitions, and standards for the data to be submitted, and shall require managed care and county-based purchasing plans to comply with these criteria, definitions, and standards when submitting data under this section. In carrying out the responsibilities of this subdivision, the commissioner shall ensure that the data collection is implemented in an integrated and coordinated manner that avoids unnecessary duplication of effort. To the extent possible, the commissioner shall use existing data sources and streamline data collection in order to reduce public and private sector administrative costs. Nothing in this subdivision shall allow release of information that is nonpublic data pursuant to section 13.02.

(b) Effective January 1, 2014, each managed care and county-based purchasing plan must quarterly provide to the commissioner the following information on state public programs, in the form and manner specified by the commissioner, according to guidelines developed by the commissioner in consultation with managed care plans and county-based purchasing plans under contract:

(1) an income statement by program;

(2) financial statement footnotes;

(3) quarterly profitability by program and population group;

(4) a medical liability summary by program and population group;

(5) received but unpaid claims report by program;

(6) services versus payment lags by program for hospital services, outpatient services, physician services, other medical services, and pharmaceutical benefits;

(7) utilization reports that summarize utilization and unit cost information by program for hospitalization services, outpatient services, physician services, and other medical services;

(8) pharmaceutical statistics by program and population group for measures of price and utilization of pharmaceutical services;

(9) subcapitation expenses by population group;

(10) third-party payments by program;

(11) all new, active, and closed subrogation cases by program;

(12) all new, active, and closed fraud and abuse cases by program;

(13) medical loss ratios by program;

(14) administrative expenses by category and subcategory by program that reconcile to other state and federal regulatory agencies;

(15) revenues by program, including investment income;

(16) nonadministrative service payments, provider payments, and reimbursement rates by provider type or service category, by program, paid by the managed care plan under this section or the county-based purchasing plan under section 256B.692 to providers and vendors for administrative services under contract with the plan, including but not limited to:

(i) individual-level provider payment and reimbursement rate data;

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(ii) provider reimbursement rate methodologies by provider type, by program, including a description of alternative payment arrangements and payments outside the claims process;

(iii) data on implementation of legislatively mandated provider rate changes; and

(iv) individual-level provider payment and reimbursement rate data and plan-specific provider reimbursement rate methodologies by provider type, by program, including alternative payment arrangements and payments outside the claims process, provided to the commissioner under this subdivision are nonpublic data as defined in section 13.02;

(17) data on the amount of reinsurance or transfer of risk by program; and

(18) contribution to reserve, by program.

(c) In the event a report is published or released based on data provided under this subdivision, the commissioner shall provide the report to managed care plans and county-based purchasing plans 15 days prior to the publication or release of the report. Managed care plans and county-based purchasing plans shall have 15 days to review the report and provide comment to the commissioner.

The quarterly reports shall be submitted to the commissioner no later than 60 days after the end of the previous quarter, except the fourth-quarter report, which shall be submitted by April 1 of each year. The fourth-quarter report shall include audited financial statements, parent company audited financial statements, an income statement reconciliation report, and any other documentation necessary to reconcile the detailed reports to the audited financial statements.

Subd. 9d. **Financial audit.** (a) The legislative auditor shall contract with an audit firm to conduct a biennial independent third-party financial audit of the information required to be provided by managed care plans and county-based purchasing plans under subdivision 9c, paragraph (b). The audit shall be conducted in accordance with generally accepted government auditing standards issued by the United States Government Accountability Office. The contract with the audit firm shall be designed and administered so as to render the independent third-party audit eligible for a federal subsidy, if available. The contract shall require the audit to include a determination of compliance with the federal Medicaid rate certification process. The contract shall require the audit to determine if the administrative expenses and investment income reported by the managed care plans and county-based purchasing plans are compliant with state and federal law.

(b) For purposes of this subdivision, "independent third party" means an audit firm that is independent in accordance with government auditing standards issued by the United States Government Accountability Office and licensed in accordance with chapter 326A. An audit firm under contract to provide services in accordance with this subdivision must not have provided services to a managed care plan or county-based purchasing plan during the period for which the audit is being conducted.

(c) The commissioner shall require, in the request for bids and resulting contracts with managed care plans and county-based purchasing plans under this section and section 256B.692, that each managed care plan and county-based purchasing plan submit to and fully cooperate with the independent third-party financial audit of the information required under subdivision 9c, paragraph (b). Each contract with a managed care plan or county-based purchasing plan under this section or section 256B.692 must provide the commissioner and the audit firm contracting with the legislative auditor access to all data required to complete the audit. For purposes of this subdivision, the contracting audit firm shall have the same investigative power as the legislative auditor under section 3.978, subdivision 2.

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(d) Each managed care plan and county-based purchasing plan providing services under this section shall provide to the commissioner biweekly encounter data and claims data for state public health care programs and shall participate in a quality assurance program that verifies the timeliness, completeness, accuracy, and consistency of the data provided. The commissioner shall develop written protocols for the quality assurance program and shall make the protocols publicly available. The commissioner shall contract for an independent third-party audit to evaluate the quality assurance protocols as to the capacity of the protocols to ensure complete and accurate data and to evaluate the commissioner's implementation of the protocols. The audit firm under contract to provide this evaluation must meet the requirements in paragraph (b).

(e) Upon completion of the audit under paragraph (a) and receipt by the legislative auditor, the legislative auditor shall provide copies of the audit report to the commissioner, the state auditor, the attorney general, and the chairs and ranking minority members of the health and human services finance committees of the legislature. Upon completion of the evaluation under paragraph (d), the commissioner shall provide copies of the report to the legislative auditor and the chairs and ranking minority members of the health finance committees of the legislature.

(f) Any actuary under contract with the commissioner to provide actuarial services must meet the independence requirements under the professional code for fellows in the Society of Actuaries and must not have provided actuarial services to a managed care plan or county-based purchasing plan that is under contract with the commissioner pursuant to this section and section 256B.692 during the period in which the actuarial services are being provided. An actuary or actuarial firm meeting the requirements of this paragraph must certify and attest to the rates paid to the managed care plans and county-based purchasing plans under this section and section 256B.692, and the certification and attestation must be auditable.

(g) Nothing in this subdivision shall allow the release of information that is nonpublic data pursuant to section 13.02.

Subd. 10. **Information.** Notwithstanding any law or rule to the contrary, the commissioner may allow disclosure of the recipient's identity solely for the purposes of (a) allowing demonstration providers to provide the information to the recipient regarding services, access to services, and other provider characteristics, and (b) facilitating monitoring of recipient satisfaction and quality of care. The commissioner shall develop and implement measures to protect recipients from invasions of privacy and from harassment.

Subd. 11. **Appeals.** A recipient may appeal to the commissioner a demonstration provider's delay or refusal to provide services, according to section 256.045.

Subd. 12. [Repealed, 1989 c 282 art 3 s 98]

Subd. 13. [Repealed, 1989 c 282 art 3 s 98]

Subd. 14. [Repealed, 1989 c 282 art 3 s 98]

Subd. 15. [Repealed, 1989 c 282 art 3 s 98]

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

Subd. 17. **Continuation of prepaid medical assistance.** The commissioner may continue the provisions of this section in any or all of the participating counties if necessary federal authority is granted. The commissioner may adopt permanent rules to continue prepaid medical assistance in these areas.

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Subd. 18. **Services pending appeal.** If the recipient appeals in writing to the state agency on or before the tenth day after the decision of the prepaid health plan to reduce, suspend, or terminate services which the recipient had been receiving, and the treating physician or another plan physician orders the services to be continued at the previous level, the prepaid health plan must continue to provide services at a level equal to the level ordered by the plan's physician until the state agency renders its decision.

Subd. 19. **Limitation on reimbursement; providers not with prepaid health plan.** A prepaid health plan may limit any reimbursement it may be required to pay to providers not employed by or under contract with the prepaid health plan to the medical assistance rates for medical assistance enrollees paid by the commissioner of human services to providers for services to recipients not enrolled in a prepaid health plan.

Subd. 20. **Ombudsperson.** The commissioner shall designate an ombudsperson to advocate for persons required to enroll in prepaid health plans under this section. The ombudsperson shall advocate for recipients enrolled in prepaid health plans through complaint and appeal procedures and ensure that necessary medical services are provided either by the prepaid health plan directly or by referral to appropriate social services. At the time of enrollment in a prepaid health plan, the local agency shall inform recipients about the ombudsperson program and their right to a resolution of a complaint by the prepaid health plan if they experience a problem with the plan or its providers.

Subd. 21. **Prepayment coordinator.** The county board shall designate a prepayment coordinator to assist the state agency in implementing this section. Assistance must include educating recipients about available health care options, enrolling recipients under subdivision 5, providing necessary eligibility and enrollment information to health plans and the state agency, and coordinating complaints and appeals with the ombudsman established in subdivision 18.

Subd. 22. **Impact on public or teaching hospitals and community clinics.** (a) Before implementing prepaid programs in counties with a county operated or affiliated public teaching hospital or a hospital or clinic operated by the University of Minnesota, the commissioner shall consider the risks the prepaid program creates for the hospital and allow the county or hospital the opportunity to participate in the program, provided the terms of participation in the program are competitive with the terms of other participants.

(b) Prepaid health plans serving counties with a nonprofit community clinic or community health services agency must contract with the clinic or agency to provide services to clients who choose to receive services from the clinic or agency, if the clinic or agency agrees to payment rates that are competitive with rates paid to other health plan providers for the same or similar services.

(c) For purposes of this subdivision, "nonprofit community clinic" includes, but is not limited to, a community mental health center as defined in sections 245.62 and 256B.0625, subdivision 5.

Subd. 23. **Alternative services; elderly and disabled persons.** (a) The commissioner may implement demonstration projects to create alternative integrated delivery systems for acute and long-term care services to elderly persons and persons with disabilities as defined in section 256B.77, subdivision 7a, that provide increased coordination, improve access to quality services, and mitigate future cost increases. The commissioner may seek federal authority to combine Medicare and Medicaid capitation payments for the purpose of such demonstrations and may contract with Medicare-approved special needs plans that are offered by a demonstration provider or by an entity that is directly or indirectly wholly owned or controlled by a demonstration provider to provide Medicaid services. Medicare funds and services shall be administered according to the terms and conditions of the federal contract and demonstration provisions. For

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the purpose of administering medical assistance funds, demonstrations under this subdivision are subject to subdivisions 1 to 22. The provisions of Minnesota Rules, parts 9500.1450 to 9500.1464, apply to these demonstrations, with the exceptions of parts 9500.1452, subpart 2, item B; and 9500.1457, subpart 1, items B and C, which do not apply to persons enrolling in demonstrations under this section. All enforcement and rulemaking powers available under chapters 62D, 62M, and 62Q are hereby granted to the commissioner of health with respect to Medicare-approved special needs plans with which the commissioner contracts to provide Medicaid services under this section. An initial open enrollment period may be provided. Persons who disenroll from demonstrations under this subdivision remain subject to Minnesota Rules, parts 9500.1450 to 9500.1464. When a person is enrolled in a health plan under these demonstrations and the health plan's participation is subsequently terminated for any reason, the person shall be provided an opportunity to select a new health plan and shall have the right to change health plans within the first 60 days of enrollment in the second health plan. Persons required to participate in health plans under this section who fail to make a choice of health plan shall not be randomly assigned to health plans under these demonstrations. Notwithstanding section 256L.12, subdivision 5, and Minnesota Rules, part 9505.5220, subpart 1, item A, if adopted, for the purpose of demonstrations under this subdivision, the commissioner may contract with managed care organizations, including counties, to serve only elderly persons eligible for medical assistance, elderly and disabled persons, or disabled persons only. For persons with a primary diagnosis of developmental disability, serious and persistent mental illness, or serious emotional disturbance, the commissioner must ensure that the county authority has approved the demonstration and contracting design. Enrollment in these projects for persons with disabilities shall be voluntary. The commissioner shall not implement any demonstration project under this subdivision for persons with a primary diagnosis of developmental disabilities, serious and persistent mental illness, or serious emotional disturbance, without approval of the county board of the county in which the demonstration is being implemented.

(b) MS 2009 Supplement [Expired, 2003 c 47 s 4; 2007 c 147 art 7 s 60]

(c) Before implementation of a demonstration project for disabled persons, the commissioner must provide information to appropriate committees of the house of representatives and senate and must involve representatives of affected disability groups in the design of the demonstration projects.

(d) A nursing facility reimbursed under the alternative reimbursement methodology in section 256B.434 may, in collaboration with a hospital, clinic, or other health care entity provide services under paragraph (a). The commissioner shall amend the state plan and seek any federal waivers necessary to implement this paragraph.

(e) The commissioner, in consultation with the commissioners of commerce and health, may approve and implement programs for all-inclusive care for the elderly (PACE) according to federal laws and regulations governing that program and state laws or rules applicable to participating providers. A PACE provider is not required to be licensed or certified as a health plan company as defined in section 62Q.01, subdivision 4. Persons age 55 and older who have been screened by the county and found to be eligible for services under the elderly waiver or community alternatives for disabled individuals or who are already eligible for Medicaid but meet level of care criteria for receipt of waiver services may choose to enroll in the PACE program. Medicare and Medicaid services will be provided according to this subdivision and federal Medicare and Medicaid requirements governing PACE providers and programs. PACE enrollees will receive Medicaid home and community-based services through the PACE provider as an alternative to services for which they would otherwise be eligible through home and community-based waiver programs and Medicaid State Plan Services. The commissioner shall establish Medicaid rates for PACE providers that do not exceed costs that would have been incurred under fee-for-service or other relevant managed care programs operated by the state.

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(f) The commissioner shall seek federal approval to expand the Minnesota disability health options (MnDHO) program established under this subdivision in stages, first to regional population centers outside the seven-county metro area and then to all areas of the state. Until July 1, 2009, expansion for MnDHO projects that include home and community-based services is limited to the two projects and service areas in effect on March 1, 2006. Enrollment in integrated MnDHO programs that include home and community-based services shall remain voluntary. Costs for home and community-based services included under MnDHO must not exceed costs that would have been incurred under the fee-for-service program. Notwithstanding whether expansion occurs under this paragraph, in determining MnDHO payment rates and risk adjustment methods, the commissioner must consider the methods used to determine county allocations for home and community-based program participants. If necessary to reduce MnDHO rates to comply with the provision regarding MnDHO costs for home and community-based services, the commissioner shall achieve the reduction by maintaining the base rate for contract year 2010 for services provided under the community alternatives for disabled individuals waiver at the same level as for contract year 2009. The commissioner may apply other reductions to MnDHO rates to implement decreases in provider payment rates required by state law. Effective January 1, 2011, enrollment and operation of the MnDHO program in effect during 2010 shall cease. The commissioner may reopen the program provided all applicable conditions of this section are met. In developing program specifications for expansion of integrated programs, the commissioner shall involve and consult the state-level stakeholder group established in subdivision 28, paragraph (d), including consultation on whether and how to include home and community-based waiver programs. Plans to reopen MnDHO projects shall be presented to the chairs of the house of representatives and senate committees with jurisdiction over health and human services policy and finance prior to implementation.

(g) Notwithstanding section 256B.0621, health plans providing services under this section are responsible for home care targeted case management and relocation targeted case management. Services must be provided according to the terms of the waivers and contracts approved by the federal government.

Subd. 24. [Repealed, 1999 c 245 art 3 s 51]

Subd. 24a. [Repealed, 2014 c 262 art 2 s 18]

Subd. 25. **Continuation of payments through discharge.** In the event a medical assistance recipient or beneficiary enrolled in a health plan under this section is denied nursing facility services after residing in the facility for more than 180 days, any denial of medical assistance payment to a provider under this section shall be prospective only and payments to the provider shall continue until the resident is discharged or 30 days after the effective date of the service denial, whichever is sooner.

Subd. 26. **American Indian recipients.** (a) For American Indian recipients of medical assistance who are required to enroll with a demonstration provider under subdivision 4 or in a county-based purchasing entity, if applicable, under section 256B.692, medical assistance shall cover health care services provided at 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 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 the tribal governments, shall develop a plan for tribes to assist in the enrollment process for American Indian recipients enrolled in the prepaid

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medical assistance program 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. 27. **Information for persons with limited English-language proficiency.** Managed care contracts entered into under this section and section 256L.12 must require demonstration providers to provide language assistance to enrollees that ensures meaningful access to its programs and services according to Title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Department of Health and Human Services.

Subd. 28. **Medicare special needs plans; medical assistance basic health care.** (a) The commissioner may contract with demonstration providers and current or former sponsors of qualified Medicare-approved special needs plans, to provide medical assistance basic health care services to persons with disabilities, including those with developmental disabilities. Basic health care services include:

(1) those services covered by the medical assistance state plan except for ICF/DD services, home and community-based waiver services, case management for persons with developmental disabilities under section 256B.0625, subdivision 20a, and personal care and certain home care services defined by the commissioner in consultation with the stakeholder group established under paragraph (d); and

(2) basic health care services may also include risk for up to 100 days of nursing facility services for persons who reside in a noninstitutional setting and home health services related to rehabilitation as defined by the commissioner after consultation with the stakeholder group.

The commissioner may exclude other medical assistance services from the basic health care benefit set. Enrollees in these plans can access any excluded services on the same basis as other medical assistance recipients who have not enrolled.

(b) The commissioner may contract with demonstration providers and current and former sponsors of qualified Medicare special needs plans, to provide basic health care services under medical assistance to persons who are dually eligible for both Medicare and Medicaid and those Social Security beneficiaries eligible for Medicaid but in the waiting period for Medicare. The commissioner shall consult with the stakeholder group under paragraph (d) in developing program specifications for these services. Payment for Medicaid services provided under this subdivision for the months of May and June will be made no earlier than July 1 of the same calendar year.

(c) Notwithstanding subdivision 4, beginning January 1, 2012, the commissioner shall enroll persons with disabilities in managed care under this section, unless the individual chooses to opt out of enrollment. The commissioner shall establish enrollment and opt out procedures consistent with applicable enrollment procedures under this section.

(d) The commissioner shall establish a state-level stakeholder group to provide advice on managed care programs for persons with disabilities, including both MnDHO and contracts with special needs plans that provide basic health care services as described in paragraphs (a) and (b). The stakeholder group shall provide advice on program expansions under this subdivision and subdivision 23, including:

(1) implementation efforts;

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(2) consumer protections; and

(3) program specifications such as quality assurance measures, data collection and reporting, and evaluation of costs, quality, and results.

(e) Each plan under contract to provide medical assistance basic health care services shall establish a local or regional stakeholder group, including representatives of the counties covered by the plan, members, consumer advocates, and providers, for advice on issues that arise in the local or regional area.

(f) The commissioner is prohibited from providing the names of potential enrollees to health plans for marketing purposes. The commissioner shall mail no more than two sets of marketing materials per contract year to potential enrollees on behalf of health plans, at the health plan's request. The marketing materials shall be mailed by the commissioner within 30 days of receipt of these materials from the health plan. The health plans shall cover any costs incurred by the commissioner for mailing marketing materials.

Subd. 29. **Prepaid health plan rates.** In negotiating prepaid health plan contract rates, the commissioner of human services shall take into consideration, and the rates shall reflect, the anticipated savings in the medical assistance program due to extending medical assistance coverage to services provided in licensed birth centers, the anticipated use of these services within the medical assistance population, and the reduced medical assistance costs associated with the use of birth centers for normal, low-risk deliveries.

Subd. 30. **Provision of required materials in alternative formats.** (a) For the purposes of this subdivision, "alternative format" means a medium other than paper and "prepaid health plan" means managed care plans and county-based purchasing plans.

(b) A prepaid health plan may provide in an alternative format a provider directory and certificate of coverage, or materials otherwise required to be available in writing under Code of Federal Regulations, title 42, section 438.10, or under the commissioner's contract with the prepaid health plan, if the following conditions are met:

(1) the prepaid health plan, local agency, or commissioner, as applicable, informs the enrollee that:

(i) an alternative format is available and the enrollee affirmatively requests of the prepaid health plan that the provider directory, certificate of coverage, or materials otherwise required under Code of Federal Regulations, title 42, section 438.10, or under the commissioner's contract with the prepaid health plan be provided in an alternative format; and

(ii) a record of the enrollee request is retained by the prepaid health plan in the form of written direction from the enrollee or a documented telephone call followed by a confirmation letter to the enrollee from the prepaid health plan that explains that the enrollee may change the request at any time;

(2) the materials are sent to a secure electronic mailbox and are made available at a password-protected secure electronic Web site or on a data storage device if the materials contain enrollee data that is individually identifiable;

(3) the enrollee is provided a customer service number on the enrollee's membership card that may be called to request a paper version of the materials provided in an alternative format; and

(4) the materials provided in an alternative format meets all other requirements of the commissioner regarding content, size of the typeface, and any required time frames for distribution. "Required time frames for distribution" must permit sufficient time for prepaid health plans to distribute materials in alternative formats upon receipt of enrollees' requests for the materials.

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(c) A prepaid health plan may provide in an alternative format its primary care network list to the commissioner and to local agencies within its service area. The commissioner or local agency, as applicable, shall inform a potential enrollee of the availability of a prepaid health plan's primary care network list in an alternative format. If the potential enrollee requests an alternative format of the prepaid health plan's primary care network list, a record of that request shall be retained by the commissioner or local agency. The potential enrollee is permitted to withdraw the request at any time.

The prepaid health plan shall submit sufficient paper versions of the primary care network list to the commissioner and to local agencies within its service area to accommodate potential enrollee requests for paper versions of the primary care network list.

(d) A prepaid health plan may provide in an alternative format materials otherwise required to be available in writing under Code of Federal Regulations, title 42, section 438.10, or under the commissioner's contract with the prepaid health plan, if the conditions of paragraphs (b) and (c) are met for persons who are eligible for enrollment in managed care.

(e) The commissioner shall consult with managed care plans, county-based purchasing plans, counties, and other interested parties to determine how materials required to be made available to enrollees under Code of Federal Regulations, title 42, section 438.10, or under the commissioner's contract with a prepaid health plan may be provided in an alternative format on the basis that the enrollee has not opted in to receive the alternative format. The commissioner shall consult with managed care plans, county-based purchasing plans, counties, and other interested parties to develop recommendations relating to the conditions that must be met for an opt-out process to be granted.

Subd. 31. **Payment reduction.** (a) Beginning September 1, 2011, the commissioner shall reduce payments and limit future rate increases paid to managed care plans and county-based purchasing plans. The limits in paragraphs (a) to (f) shall be achieved on a statewide aggregate basis by program. The commissioner may use competitive bidding, payment reductions, or other reductions to achieve the reductions and limits in this subdivision.

(b) Beginning September 1, 2011, the commissioner shall reduce payments to managed care plans and county-based purchasing plans as follows:

(1) 2.0 percent for medical assistance elderly basic care. This shall not apply to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

(2) 2.82 percent for medical assistance families and children;

(3) 10.1 percent for medical assistance adults without children; and

(4) 6.0 percent for MinnesotaCare families and children.

(c) Beginning January 1, 2012, the commissioner shall limit rates paid to managed care plans and county-based purchasing plans for calendar year 2012 to a percentage of the rates in effect on August 31, 2011, as follows:

(1) 98 percent for medical assistance elderly basic care. This shall not apply to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

(2) 97.18 percent for medical assistance families and children;

(3) 89.9 percent for medical assistance adults without children; and

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(4) 94 percent for MinnesotaCare families and children.

(d) Beginning January 1, 2013, to December 31, 2013, the commissioner shall limit the maximum annual trend increases to rates paid to managed care plans and county-based purchasing plans as follows:

(1) 7.5 percent for medical assistance elderly basic care. This shall not apply to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

(2) 5.0 percent for medical assistance special needs basic care;

(3) 2.0 percent for medical assistance families and children;

(4) 3.0 percent for medical assistance adults without children;

(5) 3.0 percent for MinnesotaCare families and children; and

(6) 3.0 percent for MinnesotaCare adults without children.

(e) The commissioner may limit trend increases to less than the maximum. Beginning July 1, 2014, the commissioner shall limit the maximum annual trend increases to rates paid to managed care plans and county-based purchasing plans as follows for calendar years 2014 and 2015:

(1) 7.5 percent for medical assistance elderly basic care. This shall not apply to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

(2) 5.0 percent for medical assistance special needs basic care;

(3) 2.0 percent for medical assistance families and children;

(4) 3.0 percent for medical assistance adults without children;

(5) 3.0 percent for MinnesotaCare families and children; and

(6) 4.0 percent for MinnesotaCare adults without children.

The commissioner may limit trend increases to less than the maximum. For calendar year 2014, the commissioner shall reduce the maximum aggregate trend increases by $47,000,000 in state and federal funds to account for the reductions in administrative expenses in subdivision 5i.

Subd. 32. **Initiatives to reduce incidence of low birth weight.** The commissioner shall require managed care and county-based purchasing plans, as a condition of contract, to implement strategies to reduce the incidence of low birth weight in geographic areas identified by the commissioner as having a higher than average incidence of low birth weight. The strategies must coordinate health care with social services and the local public health system. Each plan shall develop and report to the commissioner outcome measures related to reducing the incidence of low birth weight. The commissioner shall consider the outcomes reported when considering plan participation in the competitive bidding program established under subdivision 33.

Subd. 32a. **Initiatives to improve early screening, diagnosis, and treatment of children with autism spectrum disorder and other developmental conditions.** (a) The commissioner shall require managed care plans and county-based purchasing plans, as a condition of contract, to implement strategies that facilitate access for young children between the ages of one and three years to periodic developmental and

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social-emotional screenings, as recommended by the Minnesota Interagency Developmental Screening Task Force, and that those children who do not meet milestones are provided access to appropriate evaluation and assessment, including treatment recommendations, expected to improve the child's functioning, with the goal of meeting milestones by age five.

(b) The following information from encounter data provided to the commissioner shall be reported on the department's public Web site for each managed care plan and county-based purchasing plan annually by July 31 of each year beginning in 2014:

(1) the number of children who received a diagnostic assessment;

(2) the total number of children ages one to six with a diagnosis of autism spectrum disorder who received treatments;

(3) the number of children identified under clause (2) reported by each 12-month age group beginning with age one and ending with age six; and

(4) the types of treatments provided to children identified under clause (2) listed by billing code, including the number of units billed for each child.

(c) The managed care plans and county-based purchasing plans shall also report on any barriers to providing screening, diagnosis, and treatment of young children between the ages of one and three years, any strategies implemented to address those barriers, and make recommendations on how to measure and report on the effectiveness of the strategies implemented to facilitate access for young children to provide developmental and social-emotional screening, diagnosis, and treatment as described in paragraph (a).

Subd. 33. **Competitive bidding.** (a) For managed care contracts effective on or after January 1, 2014, the commissioner may utilize a competitive price bidding program for nonelderly, nondisabled adults and children in medical assistance and MinnesotaCare in the seven-county metropolitan area. The program must allow a minimum of two managed care plans to serve the metropolitan area.

(b) In designing the competitive bid program, the commissioner shall consider, and incorporate where appropriate, the procedures and criteria used in the competitive bidding pilot authorized under Laws 2011, First Special Session chapter 9, article 6, section 96. The pilot program operating in Hennepin County under the authority of section 256B.0756 shall continue to be exempt from competitive bid.

(c) The commissioner shall use past performance data as a factor in selecting vendors and shall consider this information, along with competitive bid and other information, in determining whether to contract with a managed care plan under this subdivision. Where possible, the assessment of past performance in serving persons on public programs shall be based on encounter data submitted to the commissioner. The commissioner shall evaluate past performance based on both the health outcomes of care and success rates in securing participation in recommended preventive and early diagnostic care. Data provided by managed care plans must be provided in a uniform manner as specified by the commissioner and must include only data on medical assistance and MinnesotaCare enrollees. The data submitted must include health outcome measures on reducing the incidence of low birth weight established by the managed care plan under subdivision 32.

Subd. 34. **Supplemental recovery program.** The commissioner shall conduct a supplemental recovery program for third-party liabilities identified through coordination of benefits not recovered by managed care plans and county-based purchasing plans for state public health programs. Any third-party liability identified through coordination of benefits and recovered by the commissioner more than eight months after the date a

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managed care plan or county-based purchasing plan adjudicates a health care claim shall be retained by the commissioner and deposited in the general fund. The commissioner shall establish a mechanism, including a reconciliation process, for managed care plans and county-based purchasing plans to coordinate third-party liability collections efforts resulting from coordination of benefits under this subdivision with the commissioner to ensure there is no duplication of efforts. The coordination mechanism must be consistent with the reporting requirements in subdivision 9c. The commissioner shall share accurate and timely third-party liability data with managed care plans and county-based purchasing plans.

Subd. 35. **Statewide procurement.** (a) For calendar year 2015, the commissioner may extend a demonstration provider's contract under this section for a sixth year after the most recent procurement. For calendar year 2015, section 16B.98, subdivision 5, paragraph (b), and section 16C.05, subdivision 2, paragraph (b), shall not apply to contracts under this section.

(b) For calendar year 2016 contracts under this section, the commissioner shall procure through a statewide procurement, which includes all 87 counties, demonstration providers, and participating entities as defined in section 256L.01, subdivision 7. The commissioner shall publish a request for proposals by January 5, 2015. As part of the procurement process, the commissioner shall:

(1) seek each individual county's input;

(2) organize counties into regional groups, and consider single counties for the largest and most diverse counties; and

(3) seek regional and county input regarding the respondent's ability to fully and adequately deliver required health care services, offer an adequate provider network, provide care coordination with county services, and serve special populations, including enrollees with language and cultural needs.

History: *1983 c 312 art 5 s 27; 1984 c 654 art 5 s 58; 1987 c 403 art 2 s 95-101; 1988 c 689 art 2 s 182,183,268; 1989 c 209 art 1 s 23; 1989 c 282 art 3 s 87-90; 1990 c 426 art 1 s 29; 1990 c 568 art 3 s 83,84; 1991 c 292 art 7 s 25; 1994 c 529 s 11; 1995 c 207 art 6 s 90-102; art 7 s 41; 1995 c 234 art 6 s 40,41; 1996 c 451 art 2 s 33-37; art 5 s 32; 1997 c 203 art 2 s 26; art 4 s 48-55; 1998 c 407 art 3 s 17; art 4 s 44-48; 1999 c 159 s 53; 1999 c 245 art 2 s 38; art 3 s 37,38; art 4 s 70-75; 2000 c 340 s 12,13; 2000 c 353 s 1; 2000 c 488 art 9 s 24-26; 2001 c 161 s 49; 2001 c 203 s 14; 1Sp2001 c 9 art 2 s 49-52; 2002 c 220 art 15 s 15-19; 2002 c 275 s 5; 2002 c 281 s 1; 2002 c 375 art 2 s 43; 2002 c 379 art 1 s 113; 2003 c 47 s 3-5; 2003 c 101 s 1; 1Sp2003 c 14 art 12 s 56-65; 2004 c 228 art 1 s 75; 2004 c 268 s 14; 2004 c 288 art 3 s 26; art 5 s 9; 2005 c 56 s 1; 1Sp2005 c 4 art 7 s 46; art 8 s 51; 2006 c 282 art 20 s 28-30; 2007 c 147 art 7 s 60; art 8 s 24-26; 2008 c 326 art 1 s 35-38; 2008 c 363 art 15 s 14; art 17 s 14; 2008 c 364 s 2-6; 2009 c 79 art 5 s 46-49; art 8 s 72; 2009 c 159 s 105; 2009 c 173 art 3 s 15; 2010 c 200 art 1 s 10; 2010 c 310 art 13 s 2; art 15 s 1; 1Sp2010 c 1 art 15 s 9; art 16 s 21-23, 45; art 17 s 13; 1Sp2011 c 9 art 6 s 61-65; art 9 s 2; 1Sp2011 c 11 art 3 s 12; 2012 c 187 art 1 s 39; 2012 c 216 art 13 s 15,16; 2012 c 247 art 1 s 12-16; 2013 c 108 art 2 s 39,44; art 6 s 20-24; art 7 s 48; art 15 s 3,4; 2013 c 125 art 1 s 107; 2014 c 262 art 2 s 3-15; 2014 c 275 art 1 s 66; 2014 c 291 art 9 s 3; art 10 s 5; 2014 c 312 art 24 s 39*

256B.691 RISK-BASED TRANSPORTATION PAYMENTS.

Any contract with a prepaid health plan under the medical assistance, general assistance medical care, or MinnesotaCare program that requires the health plan to cover transportation services for obtaining medical care for eligible individuals who are ambulatory must provide for payment for those services on a risk basis.

History: *1995 c 207 art 6 s 103*

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256B.692 COUNTY-BASED PURCHASING.

Subdivision 1. **In general.** County boards or groups of county boards may elect to purchase or provide health care services on behalf of persons eligible for medical assistance who would otherwise be required to or may elect to participate in the prepaid medical assistance program according to section 256B.69. Counties that elect to purchase or provide health care under this section must provide all services included in prepaid managed care programs according to section 256B.69, subdivisions 1 to 22. County-based purchasing under this section is governed by section 256B.69, unless otherwise provided for under this section.

Subd. 2. **Duties of commissioner of health.** (a) Notwithstanding chapters 62D and 62N, a county that elects to purchase medical assistance 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 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 will be met according to the following schedule:

(1) for a county-based purchasing plan approved on or before June 30, 2008, the plan must have in reserve:

(i) at least 50 percent of the minimum amount required under chapter 62D as of January 1, 2010;

(ii) at least 75 percent of the minimum amount required under chapter 62D as of January 1, 2011;

(iii) at least 87.5 percent of the minimum amount required under chapter 62D as of January 1, 2012; and

(iv) at least 100 percent of the minimum amount required under chapter 62D as of January 1, 2013; and

(2) for a county-based purchasing plan first approved after June 30, 2008, the plan must have in reserve:

(i) at least 50 percent of the minimum amount required under chapter 62D at the time the plan begins enrolling enrollees;

(ii) at least 75 percent of the minimum amount required under chapter 62D after the first full calendar year;

(iii) at least 87.5 percent of the minimum amount required under chapter 62D after the second full calendar year; and

(iv) at least 100 percent of the minimum amount required under chapter 62D after the third full calendar year.

(c) Until a plan is required to have reserves equaling at least 100 percent of the minimum amount required under chapter 62D, the plan may demonstrate its ability to cover any losses by satisfying the requirements of chapter 62N. A county-based purchasing plan 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

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of chapter 62Q, including sections 62Q.075; 62Q.1055; 62Q.106; 62Q.12; 62Q.135; 62Q.14; 62Q.145; 62Q.19; 62Q.23, paragraph (c); 62Q.43; 62Q.47; 62Q.50; 62Q.52 to 62Q.56; 62Q.58; 62Q.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 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.

(f) The commissioner shall collect from a county-based purchasing plan under this section the following fees:

(1) fees attributable to the costs of audits and other examinations of plan financial operations. These fees are subject to the provisions of Minnesota Rules, part 4685.2800, subpart 1, item F; and

(2) an annual fee of $21,500, to be paid by June 15 of each calendar year.

All fees collected under this paragraph shall be deposited in the state government special revenue fund.

Subd. 3. **Requirements of the county board.** A county board that intends to purchase or provide health care under this section, which may include purchasing all or part of these services from health plans or individual providers on a fee-for-service basis, or providing these services directly, must demonstrate the ability to follow and agree to the following requirements:

(1) purchase all covered services for a fixed payment from the state that does not exceed the estimated state and federal cost that would have occurred under the prepaid medical assistance program;

(2) ensure that covered services are accessible to all enrollees and that enrollees have a reasonable choice of providers, health plans, or networks when possible. If the county is also a provider of service, the county board shall develop a process to ensure that providers employed by the county are not the sole referral source and are not the sole provider of health care services if other providers, which meet the same quality and cost requirements are available;

(3) issue payments to participating vendors or networks in a timely manner;

(4) establish a process to ensure and improve the quality of care provided;

(5) provide appropriate quality and other required data in a format required by the state;

(6) provide a system for advocacy, enrollee protection, and complaints and appeals that is independent of care providers or other risk bearers and complies with section 256B.69;

(7) ensure that the implementation and operation of the Minnesota senior health options demonstration project and the Minnesota disability health options demonstration project, authorized under section 256B.69, subdivision 23, will not be impeded;

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(8) ensure that all recipients that are enrolled in the prepaid medical assistance program will be transferred to county-based purchasing without utilizing the department's fee-for-service claims payment system;

(9) ensure that all recipients who are required to participate in county-based purchasing are given sufficient information prior to enrollment in order to make informed decisions; and

(10) ensure that the state and the medical assistance recipients will be held harmless for the payment of obligations incurred by the county if the county, or a health plan providing services on behalf of the county, or a provider participating in county-based purchasing becomes insolvent, and the state has made the payments due to the county under this section.

Subd. 4. **Payments to counties.** The commissioner shall pay counties that are purchasing or providing health care under this section a per capita payment for all enrolled recipients. Payments shall not exceed payments that otherwise would have been paid to health plans under medical assistance for that county or region. This payment is in addition to any administrative allocation to counties for education, enrollment, and advocacy. The state of Minnesota and the United States Department of Health and Human Services are not liable for any costs incurred by a county that exceed the payments to the county made under this subdivision. A county whose costs exceed the payments made by the state, or any affected enrollees or creditors of that county, shall have no rights under chapter 61B or section 62D.181. A county may assign risk for the cost of care to a third party.

Subd. 4a. **Expenditure of revenues.** (a) A county that has elected to participate in a county-based purchasing plan under this section shall use any excess revenues over expenses that are received by the county and are not needed (1) for capital reserves under subdivision 2, (2) to increase payments to providers, or (3) to repay county investments or contributions to the county-based purchasing plan, for prevention, early intervention, and health care programs, services, or activities.

(b) A county-based purchasing plan under this section is subject to the unreasonable expense provisions of section 62D.19.

Subd. 5. **County proposals.** (a) A county board that wishes to purchase or provide health care under this section must submit a preliminary proposal that substantially demonstrates the county's ability to meet all the requirements of this section in response to criteria for proposals issued by the department. Counties submitting preliminary proposals must establish a local planning process that involves input from medical assistance recipients, recipient advocates, providers and representatives of local school districts, labor, and tribal government to advise on the development of a final proposal and its implementation.

(b) The county board must submit a final proposal that demonstrates the ability to meet all the requirements of this section.

(c) For a county in which the prepaid medical assistance program is in existence, the county board must submit a preliminary proposal at least 15 months prior to termination of health plan contracts in that county and a final proposal six months prior to the health plan contract termination date in order to begin enrollment after the termination. Nothing in this section shall impede or delay implementation or continuation of the prepaid medical assistance program in counties for which the board does not submit a proposal, or submits a proposal that is not in compliance with this section.

Subd. 6. **Commissioner's authority.** The commissioner may:

(1) reject any preliminary or final proposal that:

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(a) substantially fails to meet the requirements of this section, or

(b) that the commissioner determines would substantially impair the state's ability to purchase health care services in other areas of the state, or

(c) would substantially impair an enrollee's choice of care systems when reasonable choice is possible, or

(d) would substantially impair the implementation and operation of the Minnesota senior health options demonstration project authorized under section 256B.69, subdivision 23; and

(2) assume operation of a county's purchasing of health care for enrollees in medical assistance in the event that the contract with the county is terminated.

Subd. 7. **Dispute resolution.** In the event the commissioner rejects a proposal under subdivision 6, the county board may request the recommendation of a three-person mediation panel. The commissioner shall resolve all disputes after taking into account the recommendations of the 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 person selected jointly by the designee of the commissioner of human services and the designee of the Association of Minnesota Counties. Within a reasonable period of time before the hearing, the panelists must be provided all documents and information relevant to the mediation. The parties to the mediation must be given 30 days' notice of a hearing before the mediation panel.

Subd. 8. **Appeals.** A county that conducts county-based purchasing shall be considered to be a prepaid health plan for purposes of section 256.045.

Subd. 9. **Federal approval.** The commissioner shall request any federal waivers and federal approval required to implement this section. County-based purchasing shall not be implemented without obtaining all federal approval required to maintain federal matching funds in the medical assistance program.

Subd. 10. [Repealed, 2014 c 262 art 2 s 18]

History: *1997 c 203 art 4 s 56; 1998 c 407 art 4 s 49,50; 1999 c 239 s 42; 1999 c 245 art 4 s 76; 2001 c 170 s 8; 2002 c 277 s 25; 2005 c 77 s 6; 2006 c 264 s 12; 2008 c 326 art 1 s 39; 2008 c 364 s 7,8; 2010 c 200 art 1 s 20; 1Sp2010 c 1 art 16 s 24; 2014 c 262 art 2 s 16,17*

256B.693 STATE-OPERATED SERVICES; MANAGED CARE.

Subdivision 1. **Proposals for managed care; role of state operated services.** Any proposal integrating state-operated services with managed care systems for persons with disabilities shall identify the specific role to be assumed by state-operated services and the funding arrangement in which state-operated services shall effectively operate within the managed care initiative. The commissioner shall not approve or implement the initiative that consolidates funding appropriated for state-operated services with funding for managed care initiatives for persons with disabilities.

Subd. 2. **Study by the commissioner.** To help identify appropriate state-operated services for managed care systems, the commissioner of human services shall study the integration of state-operated services into public managed care systems and make recommendations to the legislature. The commissioner's study and recommendations shall include, but shall not be limited to, the following:

(1) identification of persons with disabilities on waiting lists for services, which could be provided by state-operated services;

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(2) availability of crisis services to persons with disabilities;

(3) unmet service needs, which could be met by state-operated services; and

(4) deficiencies in managed care contracts and services, which hinder the placement and maintenance of persons with disabilities in community settings.

In conducting this study, the commissioner shall survey counties concerning their interest in and need for services that could be provided by state-operated services. The commissioner shall also consult with the appropriate exclusive bargaining unit representatives. The commissioner shall report findings to the legislature by February 1, 1998.

History: *1997 c 203 art 9 s 13*

256B.694 SOLE-SOURCE OR SINGLE-PLAN MANAGED CARE CONTRACT.

The commissioner shall consider, and may approve, contracting on a single-health plan basis with county-based purchasing plans, or with other qualified health plans that have coordination arrangements with counties, to serve persons enrolled in state public health care programs, in order to promote better coordination or integration of health care services, social services and other community-based services, provided that all requirements applicable to health plan purchasing, including those in sections 256B.69 and 256B.692, are satisfied.

History: *1Sp2005 c 4 art 8 s 84; 2006 c 264 s 15; 2008 c 364 s 10; 2013 c 108 art 1 s 27; 2014 c 275 art 1 s 67*

256B.70 DEMONSTRATION PROJECT WAIVER.

Each hospital that participates as a provider in a demonstration project, established by the commissioner of human services to deliver medical assistance, or chemical dependency services on a prepaid, capitation basis, is exempt from the prospective payment system for inpatient hospital service during the period of its participation in that project.

History: *1983 c 312 art 5 s 28; 1984 c 654 art 5 s 58; 1986 c 394 s 18*

256B.71 SOCIAL HEALTH MAINTENANCE ORGANIZATION DEMONSTRATION.

Subdivision 1. **Purpose.** The commissioner of human services may participate in social health maintenance organization demonstration projects to determine if prepayment combined with the delivery of alternative services is an effective method of delivering services while containing costs.

Subd. 2. **Case management.** Each participating provider approved by the commissioner shall serve as case manager for recipients enrolled in its plan. The participating provider shall authorize and arrange for the provision of all needed health services including but not limited to the full range of services listed in sections 256B.02, subdivision 8, and 256B.0625 in order to ensure that appropriate health care is delivered to enrollees.

Subd. 3. **Enrollment of medical assistance recipients.** Medical assistance recipients may voluntarily enroll in the social health maintenance organization projects. However, once enrolled in a project, the recipient must remain enrolled for a period of six months.

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Subd. 4. **Payment for services.** Notwithstanding section 256.966 and this chapter, the method of payment utilized for the social health maintenance organization projects shall be the method developed by the commissioner of human services in consultation with local project staff and the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services, Office of Demonstrations. This subdivision applies only to the payment method for the social health maintenance organization projects.

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

History: *1983 c 295 s 1; 1984 c 654 art 5 s 58; 1986 c 444; 1988 c 689 art 2 s 268; 2002 c 277 s 32*

256B.72 COMMISSIONER'S RECOVERY OF OVERPAYMENTS.

The commissioner shall not recover overpayments from medical assistance vendors if an administrative appeal or judicial action challenging the proposed recovery is pending.

History: *1Sp1985 c 9 art 2 s 54*

256B.73 DEMONSTRATION PROJECT FOR UNINSURED LOW-INCOME PERSONS.

Subdivision 1. **Purpose.** The purpose of the demonstration project is to determine the need for and the feasibility of establishing a statewide program of medical insurance for uninsured low-income persons.

Subd. 2. **Establishment; geographic area.** The commissioner of human services shall cooperate with a local coalition to establish a demonstration project to provide low cost medical insurance to uninsured low-income persons in Cook, Crow Wing, Lake, St. Louis, Carlton, Aitkin, Pine, Itasca, and Koochiching Counties except an individual county may be excluded as determined by the county board of commissioners. The coalition shall work with the commissioners of human services, commerce, and health and potential demonstration providers as well as other public and private organizations to determine program design, including enrollee eligibility requirements, benefits, and participation.

Subd. 3. **Definitions.** For the purposes of this section, the following terms have the meanings given:

(1) "coalition" means an organization comprised of members representative of small business, health care providers, county social service departments, health consumer groups, and the health industry, established to serve the purposes of this demonstration;

(2) "demonstration provider" means a corporation regulated under chapter 62A, 62C, or 62D;

(3) "individual provider" means a medical provider under contract to the demonstration provider to provide medical care to enrollees; and

(4) "enrollee" means a person eligible to receive coverage according to subdivision 4.

Subd. 4. **Enrollee eligibility requirements.** To be eligible for participation in the demonstration project, an enrollee must:

(1) not be eligible for Medicare, medical assistance, or general assistance medical care; and

(2) have no medical insurance or health benefits plan available through employment or other means that would provide coverage for the same medical services as provided by this demonstration.

Subd. 5. **Enrollee benefits.** (a) Eligible persons enrolled by a demonstration provider shall receive a health services benefit package that includes health services which the enrollees might reasonably require

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to be maintained in good health, including emergency care, inpatient hospital and physician care, outpatient health services, and preventive health services.

(b) Services related to chemical dependency, mental illness, vision care, dental care, and other benefits may be excluded or limited upon approval by the commissioners. The coalition may petition the commissioner of commerce or health, whichever is appropriate, for waivers that allow these benefits to be excluded or limited.

(c) The commissioners, the coalition, and demonstration providers shall work together to design a package of benefits or packages of benefits that can be provided to enrollees for an affordable monthly premium.

Subd. 6. **Enrollee participation.** The demonstration provider may terminate the coverage for an enrollee who has not made payment within the first ten calendar days of the month for which coverage is being purchased. The termination for nonpayment shall be retroactive to the first day of the month for which no payment has been made by the enrollee. The coalition will assure that participants receive adequate information about the demonstration nature of the project. The coalition will assist enrollees with finding alternative coverage at the conclusion of the demonstration project.

Subd. 7. **Contract with coalition.** The commissioner of human services shall contract with the coalition to administer and direct the demonstration project and to select and retain the demonstration provider for the duration of the project. This contract shall be for 24 months with an option to renew for no more than 12 months. This contract may be canceled without cause by the commissioner upon 90 days' written notice to the coalition or by the coalition with 90 days' written notice to the commissioner. The commissioner shall assure the cooperation of the county human services or social services staff in all counties participating in the project.

Subd. 8. **Medical assistance and general assistance medical care coordination.** To assure enrollees of uninterrupted delivery of health care services, the commissioner may pay the premium to the demonstration provider for persons who become eligible for medical assistance or general assistance medical care. To determine eligibility for medical assistance, any medical expenses for eligible services incurred by the demonstration provider shall be considered as evidence of satisfying the medical expense requirements of section 256B.056, subdivisions 4 and 5. To determine eligibility for general assistance medical care, any medical expenses for eligible services incurred by the demonstration provider shall be considered as evidence of satisfying the medical expense requirements of section 256D.03, subdivision 3.

Subd. 9. **Waiver required.** No part of the demonstration project shall become operational until any required waivers of appropriate federal regulations are obtained from the Centers for Medicare and Medicaid Services.

Subd. 10. [Repealed, 1988 c 689 art 2 s 269]

History: *1987 c 337 s 123; 1988 c 689 art 2 s 184,268; 1990 c 454 s 1; 1990 c 568 art 3 s 85; 2002 c 277 s 32*

256B.74 SPECIAL PAYMENTS.

Subdivision 1. **Hospital reimbursement.** Effective for services rendered on or after July 1, 1991, the commissioner shall reimburse outpatient hospital facility fees at 80 percent of calendar year 1990 submitted

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charges, not to exceed the Medicare upper payment limit. Services excepted from this payment methodology are emergency room facility fees, clinic facility fees, and those services for which there is a federal maximum allowable payment.

Subd. 2. [Repealed, 1999 c 245 art 4 s 120]

Subd. 3. [Repealed, 2000 c 449 s 15]

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

Subd. 5. [Repealed, 1999 c 245 art 4 s 120]

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

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

Subd. 8. [Repealed, 1992 c 513 art 7 s 135]

Subd. 9. [Repealed, 1992 c 513 art 7 s 135]

Subd. 10. **Implementation; rulemaking.** The commissioner shall implement sections 256.9657 and 256B.74 on July 1, 1991, without complying with the rulemaking requirements of the Administrative Procedure Act. The commissioner may adopt rules to implement Laws 1991, chapter 292, article 4. Rules adopted to implement Laws 1991, chapter 292, article 4, supersede any provisions adopted under the exemption from rulemaking requirements in this section.

History: *1991 c 292 art 4 s 67; 1992 c 464 art 1 s 30; 1992 c 513 art 7 s 123,124; 1996 c 305 art 2 s 53*

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 (9), shall be

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paid on a cost-based payment system that is based on the cost-finding methods and allowable costs of the Medicare program.

(c) Effective for services provided on or after July 1, 2003, rates that are based on the Medicare outpatient prospective payment system shall be replaced by a budget neutral prospective payment system that is derived using medical assistance data. The commissioner shall provide a proposal to the 2003 legislature to define and implement this provision.

(d) For fee-for-service services provided on or after July 1, 2002, the total payment, before third-party liability and spenddown, made to hospitals for outpatient hospital facility services is reduced by .5 percent from the current statutory rate.

(e) In addition to the reduction in paragraph (d), the total payment for fee-for-service services provided on or after July 1, 2003, made to hospitals for outpatient hospital facility services before third-party liability and spenddown, is reduced five percent from the current statutory rates. Facilities defined under section 256.969, subdivision 16, are excluded from this paragraph.

(f) In addition to the reductions in paragraphs (d) and (e), the total payment for fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient hospital facility services before third-party liability and spenddown, is reduced three percent from the current statutory rates. Mental health services and facilities defined under section 256.969, subdivision 16, are excluded from this paragraph.

History: *1992 c 513 art 7 s 130; 1999 c 245 art 4 s 77; 1Sp2001 c 9 art 2 s 53; 2002 c 220 art 15 s 20; 2002 c 275 s 6; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 12 s 66; 2005 c 98 art 2 s 13; 2008 c 363 art 17 s 15; 2012 c 187 art 1 s 40*

256B.756 REIMBURSEMENT RATES FOR BIRTHS.

Subdivision 1. **Provider rate.** (a) Notwithstanding section 256B.76, effective for services provided on or after October 1, 2009, the payment rate for professional services related to labor, delivery, and antepartum and postpartum care when provided for any of the diagnostic categories identified in paragraph (b) shall be calculated using the methodology specified in paragraph (b).

(b) The commissioner shall calculate a single rate for the following diagnosis-related groups, as they fall within the diagnostic categories: (1) 371 cesarean sections without complicating diagnosis; (2) 372 vaginal delivery with complicating diagnosis; and (3) 373 vaginal delivery without complicating diagnosis. The rate shall be consistent with an increase in the proportion of births by vaginal delivery and a reduction in the percentage of births by cesarean section. The calculated single rate must not reflect a shift of greater than five percent in the current proportion of all births delivered vaginally and by cesarean section.

(c) The rates described in this subdivision do not include newborn care.

Subd. 2. [Repealed by amendment, 2009 c 173 art 1 s 31]

Subd. 3. **Health plans.** Payments to managed care and county-based purchasing plans under sections 256B.69, 256B.692, or 256L.12 shall be reduced for services provided on or after October 1, 2009, to reflect the adjustments in subdivision 1.

Subd. 4. **Prior authorization.** Prior authorization shall not be required before reimbursement is paid for a cesarean section delivery.

History: *2009 c 79 art 5 s 50; 2009 c 173 art 1 s 31*

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256B.76 PHYSICIAN AND DENTAL REIMBURSEMENT.

Subdivision 1. **Physician 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 Centers for Medicare and Medicaid Services' common procedural coding system codes titled "office and other outpatient services," "preventive medicine new and established patient," "delivery, antepartum, and postpartum care," "critical care," cesarean delivery and pharmacologic management provided to psychiatric patients, and 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; and

(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.

(b) 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. The increases in this paragraph shall be implemented January 1, 2000, for managed care.

(c) Effective for services rendered on or after July 1, 2009, payment rates for physician and professional services shall be reduced by five percent, except that for the period July 1, 2009, through June 30, 2010, payment rates shall be reduced by 6.5 percent for the medical assistance and general assistance medical care programs, over the rates in effect on June 30, 2009. This reduction and the reductions in paragraph (d) do not apply to office or other outpatient visits, preventive medicine visits and family planning visits billed by physicians, advanced practice nurses, or physician assistants in a family planning agency or in one of the following primary care practices: general practice, general internal medicine, general pediatrics, general geriatrics, and family medicine. This reduction and the reductions in paragraph (d) do not apply to federally qualified health centers, rural health centers, and Indian health services. Effective October 1, 2009, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.

(d) Effective for services rendered on or after July 1, 2010, payment rates for physician and professional services shall be reduced an additional seven percent over the five percent reduction in rates described in paragraph (c). This additional reduction does not apply to physical therapy services, occupational therapy services, and speech pathology and related services provided on or after July 1, 2010. This additional reduction does not apply to physician services billed by a psychiatrist or an advanced practice nurse with a specialty in mental health. Effective October 1, 2010, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.

(e) Effective for services rendered on or after September 1, 2011, through June 30, 2013, payment rates for physician and professional services shall be reduced three percent from the rates in effect on August 31, 2011. This reduction does not apply to physical therapy services, occupational therapy services, and speech pathology and related services.

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(f) Effective for services rendered on or after September 1, 2014, payment rates for physician and professional services, including physical therapy, occupational therapy, speech pathology, and mental health services shall be increased by five percent from the rates in effect on August 31, 2014. In calculating this rate increase, the commissioner shall not include in the base rate for August 31, 2014, the rate increase provided under section 256B.76, subdivision 7. This increase does not apply to federally qualified health centers, rural health centers, and Indian health services. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

Subd. 2. **Dental reimbursement.** (a) 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; and

(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.

(b) Beginning October 1, 1999, the payment for tooth sealants and fluoride treatments shall be the lower of (1) submitted charge, or (2) 80 percent of median 1997 charges.

(c) 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.

(d) Effective for services provided on or after January 1, 2002, payment for diagnostic examinations and dental x-rays provided to children under age 21 shall be the lower of (1) the submitted charge, or (2) 85 percent of median 1999 charges.

(e) The increases listed in paragraphs (b) and (c) shall be implemented January 1, 2000, for managed care.

(f) Effective for dental services rendered on or after October 1, 2010, by a state-operated dental clinic, payment shall be paid on a reasonable cost basis that is based on the Medicare principles of reimbursement. This payment shall be effective for services rendered on or after January 1, 2011, to recipients enrolled in managed care plans or county-based purchasing plans.

(g) Beginning in fiscal year 2011, if the payments to state-operated dental clinics in paragraph (f), including state and federal shares, are less than $1,850,000 per fiscal year, a supplemental state payment equal to the difference between the total payments in paragraph (f) and $1,850,000 shall be paid from the general fund to state-operated services for the operation of the dental clinics.

(h) If the cost-based payment system for state-operated dental clinics described in paragraph (f) does not receive federal approval, then state-operated dental clinics shall be designated as critical access dental providers under subdivision 4, paragraph (b), and shall receive the critical access dental reimbursement rate as described under subdivision 4, paragraph (a).

(i) Effective for services rendered on or after September 1, 2011, through June 30, 2013, payment rates for dental services shall be reduced by three percent. This reduction does not apply to state-operated dental clinics in paragraph (f).

(j) Effective for services rendered on or after January 1, 2014, payment rates for dental services shall be increased by five percent from the rates in effect on December 31, 2013. This increase does not apply

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to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, and Indian health services. Effective January 1, 2014, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment increase described in this paragraph.

Subd. 3. **Dental services grants.** (a) The commissioner shall award grants to community clinics or other nonprofit community organizations, political subdivisions, professional associations, or other organizations that demonstrate the ability to provide dental services effectively to public program recipients. Grants may be used to fund the costs related to coordinating access for recipients, developing and implementing patient care criteria, upgrading or establishing new facilities, acquiring furnishings or equipment, recruiting new providers, or other development costs that will improve access to dental care in a region. In awarding grants, the commissioner shall give priority to applicants that plan to serve areas of the state in which the number of dental providers is not currently sufficient to meet the needs of recipients of public programs or uninsured individuals. The commissioner shall consider the following in awarding the grants:

(1) potential to successfully increase access to an underserved population;

(2) the ability to raise matching funds;

(3) the long-term viability of the project to improve access beyond the period of initial funding;

(4) the efficiency in the use of the funding; and

(5) the experience of the proposers in providing services to the target population.

(b) The commissioner shall monitor the grants and may terminate a grant if the grantee does not increase dental access for public program recipients. The commissioner shall consider grants for the following:

(1) implementation of new programs or continued expansion of current access programs that have demonstrated success in providing dental services in underserved areas;

(2) a pilot program for utilizing hygienists outside of a traditional dental office to provide dental hygiene services; and

(3) 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.

Subd. 4. **Critical access dental providers.** (a) Effective for dental services rendered on or after January 1, 2002, the commissioner shall increase reimbursements to dentists and dental clinics deemed by the commissioner to be critical access dental providers. For dental services rendered on or after July 1, 2007, the commissioner shall increase reimbursement by 35 percent above the reimbursement rate that would otherwise be paid to the critical access dental provider. The commissioner shall pay the managed care plans and county-based purchasing plans in amounts sufficient to reflect increased reimbursements to critical access dental providers as approved by the commissioner.

(b) The commissioner shall designate the following dentists and dental clinics as critical access dental providers:

(1) nonprofit community clinics that:

(i) have nonprofit status in accordance with chapter 317A;

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(ii) have tax exempt status in accordance with the Internal Revenue Code, section 501(c)(3);

(iii) are established to provide oral health services to patients who are low income, uninsured, have special needs, and are underserved;

(iv) have professional staff familiar with the cultural background of the clinic's patients;

(v) charge for services on a sliding fee scale designed to provide assistance to low-income patients based on current poverty income guidelines and family size;

(vi) do not restrict access or services because of a patient's financial limitations or public assistance status; and

(vii) have free care available as needed;

(2) federally qualified health centers, rural health clinics, and public health clinics;

(3) city or county owned and operated hospital-based dental clinics;

(4) a dental clinic or dental group owned and operated by a nonprofit corporation in accordance with chapter 317A with more than 10,000 patient encounters per year with patients who are uninsured or covered by medical assistance or MinnesotaCare;

(5) a dental clinic owned and operated by the University of Minnesota or the Minnesota State Colleges and Universities system; and

(6) private practicing dentists if:

(i) the dentist's office is located within a health professional shortage area as defined under Code of Federal Regulations, title 42, part 5, and United States Code, title 42, section 254E;

(ii) more than 50 percent of the dentist's patient encounters per year are with patients who are uninsured or covered by medical assistance or MinnesotaCare;

(iii) the dentist does not restrict access or services because of a patient's financial limitations or public assistance status; and

(iv) the level of service provided by the dentist is critical to maintaining adequate levels of patient access within the service area in which the dentist operates.

(c) A designated critical access clinic shall receive the reimbursement rate specified in paragraph (a) for dental services provided off site at a private dental office if the following requirements are met:

(1) the designated critical access dental clinic is located within a health professional shortage area as defined under Code of Federal Regulations, title 42, part 5, and United States Code, title 42, section 254E, and is located outside the seven-county metropolitan area;

(2) the designated critical access dental clinic is not able to provide the service and refers the patient to the off-site dentist;

(3) the service, if provided at the critical access dental clinic, would be reimbursed at the critical access reimbursement rate;

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(4) the dentist and allied dental professionals providing the services off site are licensed and in good standing under chapter 150A;

(5) the dentist providing the services is enrolled as a medical assistance provider;

(6) the critical access dental clinic submits the claim for services provided off site and receives the payment for the services; and

(7) the critical access dental clinic maintains dental records for each claim submitted under this paragraph, including the name of the dentist, the off-site location, and the license number of the dentist and allied dental professionals providing the services.

Subd. 5. **Outpatient rehabilitation facility.** 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 subdivision 1, 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.

Subd. 6. **Medicare relative value units.** Effective for services rendered on or after January 1, 2007, the commissioner shall make payments for physician and professional services based on the Medicare relative value units (RVU's). This change shall be budget neutral and the cost of implementing RVU's will be incorporated in the established conversion factor.

Subd. 7. **Payment for certain primary care services and immunization administration.** Payment for certain primary care services and immunization administration services rendered on or after January 1, 2013, through December 31, 2014, shall be made in accordance with section 1902(a)(13) of the Social Security Act.

History: *1992 c 513 art 7 s 131; 1Sp1993 c 1 art 5 s 123; 1999 c 245 art 4 s 78; 1Sp2001 c 9 art 2 s 54; 2002 c 277 s 32; 2002 c 375 art 2 s 44; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 2 s 39; art 12 s 67; 2006 c 282 art 16 s 9; 2007 c 147 art 5 s 14; 2009 c 79 art 5 s 51; 2009 c 173 art 1 s 32; 1Sp2010 c 1 art 15 s 10,11; art 16 s 25-27; 1Sp2011 c 9 art 6 s 66-68; 2012 c 247 art 1 s 17; 2013 c 108 art 6 s 25-28*

NOTE: The amendment to subdivision 4 by Laws 2012, chapter 247, article 1, section 17, is effective July 1, 2012, or upon federal approval, whichever is later. Laws 2012, chapter 247, article 1, section 17, the effective date.

256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.

(a) Effective for services rendered on or after July 1, 2001, payment for medication management provided to psychiatric patients, outpatient mental health services, day treatment services, home-based mental health services, and family community support services shall be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the 50th percentile of 1999 charges.

(b) Effective July 1, 2001, the medical assistance rates for outpatient mental health services provided by an entity that operates: (1) a Medicare-certified comprehensive outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1, 1993, with at least 33 percent of the clients receiving reha-

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bilitation services in the most recent calendar year who are medical assistance recipients, will be increased by 38 percent, when those services are provided within the comprehensive outpatient rehabilitation facility and provided to residents of nursing facilities owned by the entity.

(c) The commissioner shall establish three levels of payment for mental health diagnostic assessment, based on three levels of complexity. The aggregate payment under the tiered rates must not exceed the projected aggregate payments for mental health diagnostic assessment under the previous single rate. The new rate structure is effective January 1, 2011, or upon federal approval, whichever is later.

(d) In addition to rate increases otherwise provided, the commissioner may restructure coverage policy and rates to improve access to adult rehabilitative mental health services under section 256B.0623 and related mental health support services under section 256B.021, subdivision 4, paragraph (f), clause (2). For state fiscal years 2015 and 2016, the projected state share of increased costs due to this paragraph is transferred from adult mental health grants under sections 245.4661 and 256E.12. The transfer for fiscal year 2016 is a permanent base adjustment for subsequent fiscal years. Payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the rate changes described in this paragraph.

History: *1Sp2001 c 9 art 9 s 43; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 2 s 40; 2010 c 303 s 6; 2013 c 108 art 4 s 28*

256B.762 REIMBURSEMENT FOR HEALTH CARE SERVICES.

Effective for services provided on or after October 1, 2005, payment rates for the following services shall be increased by five percent over the rates in effect on September 30, 2005, when these services are provided as home health services under section 256B.0625, subdivision 6a:

(1) skilled nursing visit;

(2) physical therapy visit;

(3) occupational therapy visit;

(4) speech therapy visit; and

(5) home health aide visit.

History: *1Sp2005 c 4 art 7 s 47*

256B.763 CRITICAL ACCESS MENTAL HEALTH RATE INCREASE.

(a) For services defined in paragraph (b) and rendered on or after July 1, 2007, payment rates shall be increased by 23.7 percent over the rates in effect on January 1, 2006, for:

(1) psychiatrists and advanced practice registered nurses with a psychiatric specialty;

(2) community mental health centers under section 256B.0625, subdivision 5; and

(3) mental health clinics and centers certified under Minnesota Rules, parts 9520.0750 to 9520.0870, or hospital outpatient psychiatric departments that are designated as essential community providers under section 62Q.19.

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(b) This increase applies to group skills training when provided as a component of children's therapeutic services and support, psychotherapy, medication management, evaluation and management, diagnostic assessment, explanation of findings, psychological testing, neuropsychological services, direction of behavioral aides, and inpatient consultation.

(c) This increase does not apply to rates that are governed by section 256B.0625, subdivision 30, or 256B.761, paragraph (b), other cost-based rates, rates that are negotiated with the county, rates that are established by the federal government, or rates that increased between January 1, 2004, and January 1, 2005.

(d) The commissioner shall adjust rates paid to prepaid health plans under contract with the commissioner to reflect the rate increases provided in paragraphs (a), (e), and (f). The prepaid health plan must pass this rate increase to the providers identified in paragraphs (a), (e), (f), and (g).

(e) Payment rates shall be increased by 23.7 percent over the rates in effect on December 31, 2007, for:

(1) medication education services provided on or after January 1, 2008, by adult rehabilitative mental health services providers certified under section 256B.0623; and

(2) mental health behavioral aide services provided on or after January 1, 2008, by children's therapeutic services and support providers certified under section 256B.0943.

(f) For services defined in paragraph (b) and rendered on or after January 1, 2008, by children's therapeutic services and support providers certified under section 256B.0943 and not already included in paragraph (a), payment rates shall be increased by 23.7 percent over the rates in effect on December 31, 2007.

(g) Payment rates shall be increased by 2.3 percent over the rates in effect on December 31, 2007, for individual and family skills training provided on or after January 1, 2008, by children's therapeutic services and support providers certified under section 256B.0943.

History: *2006 c 282 art 16 s 10; 2007 c 147 art 8 s 27*

256B.764 REIMBURSEMENT FOR FAMILY PLANNING SERVICES.

(a) Effective for services rendered on or after July 1, 2007, payment rates for family planning services shall be increased by 25 percent over the rates in effect June 30, 2007, when these services are provided by a community clinic as defined in section 145.9268, subdivision 1.

(b) Effective for services rendered on or after July 1, 2013, payment rates for family planning services shall be increased by 20 percent over the rates in effect June 30, 2013, when these services are provided by a community clinic as defined in section 145.9268, subdivision 1. The commissioner shall adjust capitation rates to managed care and county-based purchasing plans to reflect this increase, and shall require plans to pass on the full amount of the rate increase to eligible community clinics, in the form of higher payment rates for family planning services.

History: *2007 c 147 art 5 s 15; 2013 c 108 art 6 s 29*

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

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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 management and budget 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 developmental disabilities 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; 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; home care nursing services under section 256B.0625, subdivision 7; day training and habilitation services for adults with developmental disabilities under sections 252.41 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; 2005 c 56 s 1; 2009 c 101 art 2 s 109; 2012 c 216 art 14 s 2; 2014 c 275 art 1 s 68; 2014 c 291 art 9 s 5*

256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.

(a) Effective for services provided on or after July 1, 2009, total payments for basic care services, shall be reduced by three percent, except that for the period July 1, 2009, through June 30, 2011, total payments shall be reduced by 4.5 percent for the medical assistance and general assistance medical care programs, prior to third-party liability and spenddown calculation. Effective July 1, 2010, the commissioner shall classify physical therapy services, occupational therapy services, and speech-language pathology and related services as basic care services. The reduction in this paragraph shall apply to physical therapy services, occupational therapy services, and speech-language pathology and related services provided on or after July 1, 2010.

(b) Payments made to managed care plans and county-based purchasing plans shall be reduced for services provided on or after October 1, 2009, to reflect the reduction effective July 1, 2009, and payments made to the plans shall be reduced effective October 1, 2010, to reflect the reduction effective July 1, 2010.

(c) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for outpatient hospital facility fees shall be reduced by five percent from the rates in effect on August 31, 2011.

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(d) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for ambulatory surgery centers facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics and orthotics, renal dialysis services, laboratory services, public health nursing services, physical therapy services, occupational therapy services, speech therapy services, eyeglasses not subject to a volume purchase contract, hearing aids not subject to a volume purchase contract, and anesthesia services shall be reduced by three percent from the rates in effect on August 31, 2011.

(e) Effective for services provided on or after September 1, 2014, payments for ambulatory surgery centers facility fees, hospice services, renal dialysis services, laboratory services, public health nursing services, eyeglasses not subject to a volume purchase contract, and hearing aids not subject to a volume purchase contract shall be increased by three percent and payments for outpatient hospital facility fees shall be increased by three percent. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

(f) Payments for medical supplies and durable medical equipment not subject to a volume purchase contract, and prosthetics and orthotics, provided on or after July 1, 2014, through June 30, 2015, shall be decreased by .33 percent. Payments for medical supplies and durable medical equipment not subject to a volume purchase contract, and prosthetics and orthotics, provided on or after July 1, 2015, shall be increased by three percent from the rates in effect on June 30, 2014.

(g) This section does not apply to physician and professional services, inpatient hospital services, family planning services, mental health services, dental services, prescription drugs, medical transportation, federally qualified health centers, rural health centers, Indian health services, and Medicare cost-sharing.

History: *2009 c 79 art 5 s 52; 2009 c 173 art 1 s 42; 1Sp2010 c 1 art 15 s 12; art 16 s 28; 1Sp2011 c 9 art 6 s 69; 2013 c 108 art 6 s 30; 2014 c 312 art 24 s 40*

256B.767 MEDICARE PAYMENT LIMIT.

(a) Effective for services rendered on or after July 1, 2010, fee-for-service payment rates for physician and professional services under section 256B.76, subdivision 1, and basic care services subject to the rate reduction specified in section 256B.766, shall not exceed the Medicare payment rate for the applicable service, as adjusted for any changes in Medicare payment rates after July 1, 2010. The commissioner shall implement this section after any other rate adjustment that is effective July 1, 2010, and shall reduce rates under this section by first reducing or eliminating provider rate add-ons.

(b) This section does not apply to services provided by advanced practice certified nurse midwives licensed under chapter 148 or traditional midwives licensed under chapter 147D. Notwithstanding this exemption, medical assistance fee-for-service payment rates for advanced practice certified nurse midwives and licensed traditional midwives shall equal and shall not exceed the medical assistance payment rate to physicians for the applicable service.

(c) This section does not apply to mental health services or physician services billed by a psychiatrist or an advanced practice registered nurse with a specialty in mental health.

(d) Effective for durable medical equipment, prosthetics, orthotics, or supplies provided on or after July 1, 2013, through June 30, 2015, the payment rate for items that are subject to the rates established under Medicare's National Competitive Bidding Program shall be equal to the rate that applies to the same item when not subject to the rate established under Medicare's National Competitive Bidding Program. This

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paragraph does not apply to mail-order diabetic supplies and does not apply to items provided to dually eligible recipients when Medicare is the primary payer of the item.

History: *1Sp2010 c 1 art 16 s 29; 2013 c 108 art 6 s 31; 2014 c 312 art 24 s 41*

256B.77 COORDINATED SERVICE DELIVERY SYSTEM FOR DISABLED.

Subdivision 1. **Demonstration project for people with disabilities.** (a) The commissioner of human services, in cooperation with county authorities, shall develop and implement a demonstration project to create a coordinated service delivery system in which the full medical assistance benefit set for disabled persons eligible for medical assistance is provided and funded on a capitated basis. The demonstration period shall be a minimum of three years.

(b) Each demonstration site shall, under county authority, establish a local group to assist the commissioner in planning, designing, implementing, and evaluating the coordinated service delivery system in their area. This local group shall include county agencies, providers, consumers, family members, advocates, tribal governments, a local representative of labor, and advocacy organizations, and may include health plan companies. Consumers, families, and consumer representatives must be involved in the planning, implementation, and evaluation processes for the demonstration project.

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

(a) "Acute care" means hospital, physician, and other health and dental services covered in the medical assistance benefit set that are not specified in the intergovernmental contract or service delivery contract as continuing care services.

(b) "Additional services" means services developed and provided through the county administrative entity or service delivery organization, which are in addition to the medical assistance benefit set.

(c) "Advocate" means an individual who:

(1) has been authorized by the enrollee or the enrollee's legal representative to help the enrollee understand information presented and to speak on the enrollee's behalf, based on directions and decisions by the enrollee or the enrollee's legal representative; and

(2) represents only the enrollee and the enrollee's legal representative.

(d) "Advocacy organization" means an organization whose primary purpose is to advocate for the needs of persons with disabilities.

(e) "Alternative services" means services developed and provided through the county administrative entity or service delivery organization that are not part of the medical assistance benefit set.

(f) "Commissioner" means the commissioner of human services.

(g) "Continuing care" means any services, including long-term support services, covered in the medical assistance benefit set that are not specified in the intergovernmental contract or service delivery contract as acute care.

(h) "County administrative entity" means the county administrative structure defined and designated by the county authority to implement the demonstration project under the direction of the county authority.

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(i) "County authority" means the board of county commissioners or a single entity representing multiple boards of county commissioners.

(j) "Demonstration period" means the period of time during which county administrative entities or service delivery organizations will provide services to enrollees.

(k) "Demonstration site" means the geographic area in which eligible individuals may be included in the demonstration project.

(l) "Department" means the Department of Human Services.

(m) "Emergency" means a condition that if not immediately treated could cause a person serious physical or mental disability, continuation of severe pain, or death. Labor and delivery is an emergency if it meets this definition.

(n) "Enrollee" means an eligible individual who is enrolled in the demonstration project.

(o) "Informed choice" means a voluntary decision made by the enrollee or the enrollee's legal representative, after becoming familiar with the alternatives, and having been provided sufficient relevant written and oral information at an appropriate comprehension level and in a manner consistent with the enrollee's or the enrollee's legal representative's primary mode of communication.

(p) "Informed consent" means the written agreement, or an agreement as documented in the record, by a competent enrollee, or an enrollee's legal representative, who:

(1) has the capacity to make reasoned decisions based on relevant information;

(2) is making decisions voluntarily and without coercion; and

(3) has knowledge to make informed choice.

(q) "Intergovernmental contract" means the agreement between the commissioner and the county authority.

(r) "Legal representative" means an individual who is legally authorized to provide informed consent or make informed choices on a person's behalf. A legal representative may be one of the following individuals:

(1) the parent of a minor who has not been emancipated;

(2) a court-appointed guardian or conservator of a person who is 18 years of age or older, in areas where legally authorized to make decisions;

(3) a guardian ad litem or special guardian or conservator, in areas where legally authorized to make decisions;

(4) legal counsel if so specified by the person; or

(5) any other legally authorized individual.

The county administrative entity is prohibited from acting as legal representative for any enrollee, as long as the provisions of subdivision 15 are funded.

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(s) "Life domain areas" include, but are not limited to: home, family, education, employment, social environment, psychological and emotional health, self-care, independence, physical health, need for legal representation and legal needs, financial needs, safety, and cultural identification and spiritual needs.

(t) "Medical assistance benefit set" means the services covered under this chapter and accompanying rules which are provided according to the definition of medical necessity in Minnesota Rules, part 9505.0175, subpart 25.

(u) "Outcome" means the targeted behavior, action, or status of the enrollee that can be observed and or measured.

(v) "Personal support plan" means a document agreed to and signed by the enrollee and the enrollee's legal representative, if any, which describes:

(1) the assessed needs and strengths of the enrollee;

(2) the outcomes chosen by the enrollee or their legal representative;

(3) the amount, type, setting, start date, duration, and frequency of services and supports authorized by the county administrative entity or service delivery organization to achieve the chosen outcomes;

(4) a description of needed services and supports that are not the responsibility of the county administrative entity or service delivery organization and plans for addressing those needs;

(5) plans for referring to and coordinating between all agencies or individuals providing needed services and supports;

(6) the use of regulated treatment; and

(7) the transition of a child to the adult service system.

(w) "Regulated treatment" means any behaviorally altering medication of any classification or any aversive or deprivation procedure as defined in rules or statutes applicable to eligible individuals.

(x) "Service delivery contract" means the agreement between the commissioner or the county authority and the service delivery organization in those areas in which the county authority has provided written approval.

(y) "Service delivery organization" means an entity that is licensed as a health maintenance organization under chapter 62D or a community integrated service network under chapter 62N and is under contract with the commissioner or a county authority to participate in the demonstration project. If authorized in contract by the commissioner or the county authority, a service delivery organization participating in the demonstration project shall have the duties, responsibilities, and obligations defined under subdivisions 8, 9, 18, and 19.

(z) "Urgent situation" means circumstances in which care is needed as soon as possible, usually within 24 hours, to protect the health of an enrollee.

Subd. 3. **Assurances to commissioner of health.** A county authority that elects to participate in a demonstration project for people with disabilities under this section is not required to obtain a certificate of authority under chapter 62D or 62N. A county authority that elects to participate in a demonstration project

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for people with disabilities under this section must assure the commissioner of health that the requirements of chapters 62D and 62N, and section 256B.692, subdivision 2, are met. All enforcement and rulemaking powers available under chapters 62D, 62J, 62M, 62N, and 62Q are granted to the commissioner of health with respect to the county authorities that contract with the commissioner to purchase services in a demonstration project for people with disabilities under this section.

Subd. 4. **Federal waivers.** The commissioner, in consultation with county authorities, shall request any authority from the United States Department of Health and Human Services that is necessary to implement the demonstration project under the medical assistance program; and authority to combine Medicaid and Medicare funding for service delivery to eligible individuals who are also eligible for Medicare, only if this authority does not preclude county authority participation under the waiver. Implementation of these programs may begin without authority to include Medicare funding. The commissioner may authorize county authorities to begin enrollment of eligible individuals upon federal approval but no earlier than July 1, 1998.

Subd. 5. **Demonstration sites.** The commissioner shall designate up to two demonstration sites with the approval of the county authority. Demonstration sites may include one county or a multicounty group. At least one of the sites shall implement a model specifically addressing the needs of eligible individuals with physical disabilities. By February 1, 1998, the commissioner and the county authorities shall submit to the chairs of the senate Committee on Health and Family Security and the house of representatives Committee on Health and Human Services a phased enrollment plan to ensure an orderly transition which protects the health and safety of enrollees and ensures continuity of services.

Subd. 6. **Responsibilities of county authority.** (a) The commissioner may execute an intergovernmental contract with any county authority that demonstrates the ability to arrange for and coordinate services for enrollees covered under this section according to the terms and conditions specified by the commissioner. With the written consent of the county authority, the commissioner may issue a request for proposals for service delivery organizations to provide portions of the medical assistance benefit set not contracted for by the county authority. County authorities that do not contract for the full medical assistance benefit set must ensure coordination with the entities responsible for the remainder of the covered services.

(b) No less than 90 days before the intergovernmental contract is executed, the county authority shall submit to the commissioner an initial proposal on how it will address the areas listed in this subdivision and subdivisions 1, 7, 8, 9, 12, 18, and 19. The county authority shall submit to the commissioner annual reports describing its progress in addressing these areas.

(c) Each county authority shall develop policies to address conflicts of interest, including public guardianship and representative payee issues.

(d) Each county authority shall annually evaluate the effectiveness of the service coordination provided according to subdivision 12 and shall take remedial or corrective action if the service coordination does not fulfill the requirements of that subdivision.

Subd. 7. **Eligibility and enrollment.** The commissioner, in consultation with the county authority, shall develop a process for enrolling eligible individuals in the demonstration project. A county or counties may limit enrollment in the demonstration project to one or more of the disability populations described in subdivision 7a, paragraph (b). Enrollment into county administrative entities and service delivery organizations shall be conducted according to the terms of the federal waiver. Enrollment of eligible individuals under the demonstration project may be phased in with approval of the commissioner. The commissioner shall

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ensure that eligibility for medical assistance and enrollment for the person are determined by individuals outside of the county administrative entity.

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) developmental disability, or being a developmentally disabled 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 253D.02, subdivision 15, or a sexually dangerous person as defined in section 253D.02, subdivision 16, 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 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

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approval of the county authority, enters into a service delivery 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 intergov-

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ernmental 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 individualized education program, 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.

(u) Prepaid health plans serving counties with a nonprofit community clinic or community health services agency must contract with the clinic or agency to provide services to clients who choose to receive services from the clinic or agency, if the clinic or agency agrees to payment rates that are competitive with rates paid to other health plan providers for the same or similar services.

For purposes of this paragraph, "nonprofit community clinic" includes, but is not limited to, a community mental health center as defined in sections 245.62 and 256B.0625, subdivision 5.

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Subd. 9. **Consumer choice and safeguards.** (a) The commissioner may require all eligible individuals to obtain services covered under this chapter through county authorities. Enrollees shall be given choices among a range of available providers with expertise in serving persons of their age and with their category of disability. If the county authority is also a provider of services covered under the demonstration project, other than service coordination, the enrollee shall be given the choice of at least one other provider of that service. The commissioner shall ensure that all enrollees have continued access to medically necessary covered services.

(b) The commissioner must ensure that a set of enrollee safeguards in the categories of access, choice, comprehensive benefits, access to specialist care, disclosure of financial incentives to providers, prohibition of exclusive provider contracting and gag clauses, legal representation, guardianship, representative payee, quality, rights and appeals, privacy, data collection, and confidentiality are in place prior to enrollment of eligible individuals.

(c) If multiple service delivery organizations are offered for acute or continuing care within a demonstration site, enrollees shall be given a choice of these organizations. A choice is required if the county authority operates its own health maintenance organization, community integrated service network, or similar plan. Enrollees shall be given opportunities to change enrollment in these organizations within 12 months following initial enrollment into the demonstration project and shall also be offered an annual open enrollment period, during which they are permitted to change their service delivery organization.

(d) Enrollees shall have the option to change their primary care provider once per month.

(e) The commissioner may waive the choice of provider requirements in paragraph (a) or the choice of service delivery organization requirements in paragraph (c) if the county authority can demonstrate that, despite reasonable efforts, no other provider of the service or service delivery organization can be made available within the cost and quality requirements of the demonstration project.

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

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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 25 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 were expected by the commissioner when the capitation was set at 96 percent; and

(2) implement incentives to encourage appropriate, high quality, efficient services.

Subd. 11. **Integration of funding sources.** The county authority may integrate other local, state, and federal funding sources with medical assistance funding. The commissioner's approval is required for in-

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tegration of state and federal funds but not for local funds. During the demonstration project period, county authorities must maintain the level of local funds expended during the previous calendar year for populations covered in the demonstration project. Excluding the state share of Medicaid payments, state appropriations for state-operated services shall not be integrated unless specifically approved by the legislature. The commissioner may approve integration of other state and federal funding if the intergovernmental contract includes assurances that the people who would have been served by these funds will receive comparable or better services. The commissioner may withdraw approval for integration of state and federal funds if the county authority does not comply with these assurances. If the county authority chooses to integrate funding, it must comply with the reporting requirements of the commissioner, as specified in the intergovernmental contract, to account for federal and state Medicaid expenditures and expenditures of local funds. The commissioner, upon the request and concurrence of a county authority, may transfer state grant funds that would otherwise be made available to the county authority to provide continuing care for enrollees to the medical assistance account and, within the limits of federal authority and available federal funding, the commissioner shall adjust the capitation based on the amount of this transfer.

Subd. 12. **Service coordination.** (a) For purposes of this section, "service coordinator" means an individual selected by the enrollee or the enrollee's legal representative and authorized by the county administrative entity or service delivery organization to work in partnership with the enrollee to develop, coordinate, and in some instances, provide supports and services identified in the personal support plan. Service coordinators may only provide services and supports if the enrollee is informed of potential conflicts of interest, is given alternatives, and gives informed consent. Eligible service coordinators are individuals age 18 or older who meet the qualifications as described in paragraph (b). Enrollees, their legal representatives, or their advocates are eligible to be service coordinators if they have the capabilities to perform the activities and functions outlined in paragraph (b). Providers licensed under chapter 245A to provide residential services, or providers who are providing residential services covered under the group residential housing program, may not act as service coordinator for enrollees for whom they provide residential services. This does not apply to providers of short-term detoxification services. Each county administrative entity or service delivery organization may develop further criteria for eligible vendors of service coordination during the demonstration period and shall determine whom it contracts with or employs to provide service coordination. County administrative entities and service delivery organizations may pay enrollees or their advocates or legal representatives for service coordination activities.

(b) The service coordinator shall act as a facilitator, working in partnership with the enrollee to ensure that their needs are identified and addressed. The level of involvement of the service coordinator shall depend on the needs and desires of the enrollee. The service coordinator shall have the knowledge, skills, and abilities to, and is responsible for:

(1) arranging for an initial assessment, and periodic reassessment as necessary, of supports and services based on the enrollee's strengths, needs, choices, and preferences in life domain areas;

(2) developing and updating the personal support plan based on relevant ongoing assessment;

(3) arranging for and coordinating the provisions of supports and services, including knowledgeable and skilled specialty services and prevention and early intervention services, within the limitations negotiated with the county administrative entity or service delivery organization;

(4) assisting the enrollee and the enrollee's legal representative, if any, to maximize informed choice of and control over services and supports and to exercise the enrollee's rights and advocate on behalf of the enrollee;

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(5) monitoring the progress toward achieving the enrollee's outcomes in order to evaluate and adjust the timeliness and adequacy of the implementation of the personal support plan;

(6) facilitating meetings and effectively collaborating with a variety of agencies and persons, including attending individual family service plan and individualized education program meetings when requested by the enrollee or the enrollee's legal representative;

(7) soliciting and analyzing relevant information;

(8) communicating effectively with the enrollee and with other individuals participating in the enrollee's plan;

(9) educating and communicating effectively with the enrollee about good health care practices and risk to the enrollee's health with certain behaviors;

(10) having knowledge of basic enrollee protection requirements, including data privacy;

(11) informing, educating, and assisting the enrollee in identifying available service providers and accessing needed resources and services beyond the limitations of the medical assistance benefit set covered services; and

(12) providing other services as identified in the personal support plan.

(c) For the demonstration project, the qualifications and standards for service coordination in this section shall replace comparable existing provisions of existing statutes and rules governing case management for eligible individuals.

(d) The provisions of this subdivision apply only to the demonstration sites designated by the commissioner under subdivision 5. All other demonstration sites must comply with laws and rules governing case management services for eligible individuals in effect when the site begins the demonstration project.

Subd. 13. **Ombudsman.** Enrollees shall have access to ombudsman services established in section 256B.69, subdivision 20, and advocacy services provided by the ombudsman for mental health and developmental disabilities established in sections 245.91 to 245.97. The managed care ombudsman and the ombudsman for mental health and developmental disabilities shall coordinate services provided to avoid duplication of services. For purposes of the demonstration project, the powers and responsibilities of the Office of Ombudsman for Mental Health and Developmental Disabilities, as provided in sections 245.91 to 245.97 are expanded to include all eligible individuals, health plan companies, agencies, and providers participating in the demonstration project.

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 developmental disabilities directly, or under contract with private, nonprofit organizations, with funding provided through

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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.

Subd. 15. **Public guardianship alternatives.** Each county authority with enrollees under public guardianship shall develop a plan to discharge all those public guardianships and establish appropriate private alternatives during the demonstration period.

The commissioner shall provide county authorities with funding for public guardianship alternatives during the first year of the demonstration project based on a proposal to establish private alternatives for a specific number of enrollees under public guardianship. Funding in subsequent years shall be based on the county authority's performance in achieving discharges of public guardianship and establishing appropriate alternatives. The commissioner may establish fiscal incentives to encourage county activity in this area. For each year of the demonstration period, an appropriation is available to the commissioner based on 0.2 percent of the projected per-person costs that would otherwise have been paid under medical assistance fee-for-service for that year. This funding is in addition to the capitation payment available under subdivision 10.

Subd. 16. **Appeals.** Enrollees have the appeal rights specified in section 256.045. Enrollees may request the conciliation process as outlined under section 256.045, subdivision 4a. If an enrollee appeals in writing to the state agency on or before the latter of the effective day of the proposed action or the tenth day after they have received the decision of the county administrative entity or service delivery organization to reduce, suspend, terminate, or deny continued authorization for ongoing services which the enrollee had been receiving, the county administrative entity or service delivery organization must continue to authorize services at a level equal to the level it previously authorized until the state agency renders its decision.

Subd. 17. **Approval of alternatives.** The commissioner may approve alternatives to administrative rules if the commissioner determines that appropriate alternative measures are in place to protect the health, safety, and rights of enrollees and to assure that services are of sufficient quality to produce the outcomes described in the personal support plans. Prior approved waivers, if needed by the demonstration project, shall be extended. The commissioner shall not waive the rights or procedural protections under sections 245.825; 245.91 to 245.97; 252.41, subdivision 9; 256B.092, subdivision 10; 626.556; and 626.557; or procedures for the monitoring of psychotropic medications. Prohibited practices as defined in statutes and rules governing service delivery to eligible individuals are applicable to services delivered under this demonstration project.

Subd. 18. **Reporting.** Each county authority and service delivery organization, and their contracted providers, shall submit information as required by the commissioner in the intergovernmental contract or service delivery contract, including information about complaints, appeals, outcomes, costs, including spending on services, service utilization, identified unmet needs, services provided, rates of out-of-home placement of children, institutionalization, commitments, number of public guardianships discharged and alternatives to public guardianship established, the use of emergency services, and enrollee satisfaction. This information must be made available to enrollees and the public. A county authority under an intergovernmental contract and a service delivery organization under a service delivery contract to provide services must provide the most current listing of the providers who are participating in the plan. This listing must be provided to enrollees and be made available to the public. The commissioner, county authorities, and service delivery organizations shall also make all contracts and subcontracts related to the demonstration project available to the public.

Subd. 19. **Quality management and evaluation.** County authorities and service delivery organizations participating in this demonstration project shall provide information to the department as specified in the in-

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tergovernmental contract or service delivery contract for the purpose of project evaluation. This information may include both process and outcome evaluation measures across areas that shall include enrollee satisfaction, service delivery, service coordination, individual outcomes, and costs. An independent evaluation of each demonstration site shall be conducted prior to expansion of the demonstration project to other sites.

Subd. 20. **Limitation on reimbursement.** The county administrative entity or service delivery organization may limit any reimbursement to providers not employed by or under contract with the county administrative entity or service delivery organization to the medical assistance rates paid by the commissioner of human services to providers for services to recipients not participating in the demonstration project.

Subd. 21. **County social services obligations.** For services that are outside of the medical assistance benefit set for enrollees in excluded time status, the county of financial responsibility must negotiate the provisions and payment of services with the county of service prior to the provision of services.

Subd. 22. **Minnesota Commitment Act services.** The county administrative entity or service delivery organization is financially responsible for all services for enrollees covered by the medical assistance benefit set and ordered by the court under the Minnesota Commitment Act, chapter 253B. The county authority shall seek input from the county administrative entity or service delivery organization in giving the court information about services the enrollee needs and least restrictive alternatives. The court order for services is deemed to comply with the definition of medical necessity in Minnesota Rules, part 9505.0175. The financial responsibility of the county administrative entity or service delivery organization for regional treatment center services to an enrollee while committed to the regional treatment center is limited to 45 days following commitment. Voluntary hospitalization for enrollees at regional treatment centers must be covered by the county administrative entity or service delivery organization if deemed medically necessary by the county administrative entity or service delivery organization. The regional treatment center shall not accept a voluntary admission of an enrollee without the authorization of the county administrative entity or service delivery organization. An enrollee will maintain enrollee status while receiving treatment under the Minnesota Commitment Act or voluntary services in a regional treatment center. For enrollees committed to the regional treatment center longer than 45 days, the commissioner may adjust the aggregate capitation payments, as specified in the intergovernmental contract or service delivery contract.

Subd. 23. [Repealed, 2007 c 133 art 2 s 13]

Subd. 24. [Repealed, 2002 c 277 s 34]

Subd. 25. **Severability.** If any subdivision of this section is not approved by the United States Department of Health and Human Services, the commissioner, with the approval of the county authority, retains the authority to implement the remaining subdivisions.

Subd. 26. **Southern Minnesota health initiative pilot project.** When the commissioner contracts under subdivisions 1 and 6, paragraph (a), with the joint powers board for the southern Minnesota health initiative (SMHI) to participate in the demonstration project for persons with disabilities under subdivision 5, the commissioner shall also require health plans serving counties participating in the southern Minnesota health initiative under this section to contract with the southern Minnesota Health Initiative Joint Powers Board to provide covered mental health and chemical dependency services for the nonelderly/nondisabled persons who reside in one of the counties and who are required or elect to participate in the prepaid medical assistance and general assistance medical care programs. Enrollees may obtain covered mental health and chemical dependency services through the SMHI or through other health plan contractors. Participation of the nonelderly/nondisabled with the SMHI is voluntary. The commissioner shall identify a monthly per

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capita payment amount that health plans are required to pay to the SMHI for all nonelderly/nondisabled recipients who choose the SMHI for their mental health and chemical dependency services.

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: *1997 c 203 art 8 s 1; 1998 c 397 art 11 s 3; 1998 c 407 art 4 s 51-54; 1999 c 245 art 4 s 80-85; 2000 c 464 art 2 s 3; 2000 c 474 s 17; 2005 c 56 s 1; 2009 c 173 art 3 s 16; 1Sp2011 c 11 art 3 s 12; 2013 c 49 s 22*

256B.771 COMPLEMENTARY AND ALTERNATIVE MEDICINE DEMONSTRATION PROJECT.

Subdivision 1. **Establishment and implementation.** The commissioner of human services shall contract with a Minnesota-based academic or clinical research institution or institutions specializing in providing complementary and alternative medicine education and clinical services to establish and implement a five-year demonstration project in conjunction with federally qualified health centers or federally qualified health center "look-alikes" as defined in section 145.9269, to improve the quality and cost-effectiveness of care provided under medical assistance to enrollees with neck and back problems. The demonstration project must maximize the use of complementary and alternative medicine-oriented primary care providers, including but not limited to physicians and chiropractors. The demonstration project must be designed to significantly improve physical and mental health for enrollees who present with neck and back problems while decreasing medical treatment costs. The commissioner, in consultation with the commissioner of health, shall deliver services through the demonstration project beginning January 1, 2012, or upon federal approval, whichever is later.

Subd. 2. **RFP and project criteria.** The commissioner shall develop and issue a request for proposal (RFP) for the demonstration project. The RFP must require the academic or clinical research institution or institutions selected to demonstrate a proven track record over at least five years of conducting high-quality, federally funded clinical research. The RFP shall specify the state costs directly related to the requirements of this section and shall require that the selected institution pay those costs to the state. The institution and the federally qualified health centers and federally qualified health center "look-alikes" shall also:

(1) provide patient education, provider education, and enrollment training components on health and lifestyle issues in order to promote enrollee responsibility for health care decisions, enhance productivity, prepare enrollees to reenter the workforce, and reduce future health care expenditures;

(2) use high-quality and cost-effective integrated disease management that includes the best practices of traditional and complementary and alternative medicine;

(3) incorporate holistic medical care, appropriate nutrition, exercise, medications, and conflict resolution techniques;

(4) include a provider education component that makes use of professional organizations representing chiropractors, nurses, and other primary care providers and provides appropriate educational materials and activities in order to improve the integration of traditional medical care with licensed chiropractic services and other alternative health care services and achieve program enrollment objectives; and

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(5) provide to the commissioner the information and data necessary for the commissioner to prepare the annual reports required under subdivision 6.

Subd. 3. **Enrollment.** Enrollees from the program shall be selected by the commissioner from current enrollees in the prepaid medical assistance program who have, or are determined to be at significant risk of developing, neck and back problems. Participation in the demonstration project shall be voluntary. The commissioner shall seek to enroll, over the term of the demonstration project, ten percent of current and future medical assistance enrollees who have, or are determined to be at significant risk of developing, neck and back problems.

Subd. 4. **Federal approval.** The commissioner shall seek any federal waivers and approvals necessary to implement the demonstration project.

Subd. 5. **Project costs.** The commissioner shall require the academic or clinical research institution or institutions selected, federally qualified health centers, and federally qualified health center "look-alikes" to fund all costs of the demonstration project. Amounts received under subdivision 2 are appropriated to the commissioner for the purposes of this section.

Subd. 6. **Annual reports.** The commissioner, beginning December 15, 2012, and each December 15 thereafter through December 15, 2015, shall report annually to the legislature on the functional and mental improvements of the populations served by the demonstration project, patient satisfaction, and the cost-effectiveness of the program. The reports must also include data on hospital admissions, days in hospital, rates of outpatient surgery and other services, and drug utilization. The report, due December 15, 2015, must include recommendations on whether the demonstration project should be continued and expanded.

History: *1Sp2011 c 9 art 6 s 70*

256B.78 DEMONSTRATION PROJECT FOR FAMILY PLANNING SERVICES.

(a) The commissioner of human services shall establish a medical assistance demonstration project to determine whether improved access to coverage of prepregnancy family planning services reduces medical assistance and MFIP costs.

(b) This section is effective upon federal approval of the demonstration project.

History: *1Sp2001 c 9 art 2 s 55; 2002 c 379 art 1 s 113*

NOTE: By October 1, 2015, the commissioner of human services shall seek federal authority to operate the program in this section under the state Medicaid plan, in accordance with United States Code, title 42, section 1396a(a)(10)(A)(ii)(XXI). To be eligible, an individual must have family income at or below 200 percent of the federal poverty guidelines, except that for an individual under age 21, only the income of the individual must be considered in determining eligibility. Services under this program must be available on a presumptive eligibility basis. Laws 2014, chapter 291, article 10, section 12.

256B.81 MENTAL HEALTH PROVIDER APPEAL PROCESS.

If a county contract or certification is required to enroll as an authorized provider of mental health services under medical assistance, and if a county refuses to grant the necessary contract or certification, the provider may appeal the county decision to the commissioner. A recipient may initiate an appeal on behalf of a provider who has been denied certification. The commissioner shall determine whether the provider meets applicable standards under state laws and rules based on an independent review of the facts,

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including comments from the county review. If the commissioner finds that the provider meets the applicable standards, the commissioner shall enroll the provider as an authorized provider. The commissioner shall develop procedures for providers and recipients to appeal a county decision to refuse to enroll a provider. After the commissioner makes a decision regarding an appeal, the county, provider, or recipient may request that the commissioner reconsider the commissioner's initial decision. The commissioner's reconsideration decision is final and not subject to further appeal.

History: *1Sp2001 c 9 art 9 s 44; 2002 c 379 art 1 s 113*

256B.82 PREPAID PLANS AND MENTAL HEALTH REHABILITATIVE SERVICES.

Medical assistance and MinnesotaCare prepaid health plans may include coverage for adult mental health rehabilitative services under section 256B.0623, intensive rehabilitative services under section 256B.0622, and adult mental health crisis response services under section 256B.0624, beginning January 1, 2005.

By January 15, 2004, the commissioner shall report to the legislature how these services should be included in prepaid plans. The commissioner shall consult with mental health advocates, health plans, and counties in developing this report. The report recommendations must include a plan to ensure coordination of these services between health plans and counties, assure recipient access to essential community providers, and monitor the health plans' delivery of services through utilization review and quality standards.

History: *1Sp2001 c 9 art 9 s 45; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 3 s 51*

256B.83 [Repealed, 2006 c 282 art 16 s 17]

256B.84 AMERICAN INDIAN CONTRACTING PROVISIONS.

Notwithstanding other state laws or rules, Indian health services and agencies operated by Indian tribes are not required to have a county contract or county certification to enroll as providers of adult rehabilitative mental health services under section 256B.0623; and adult mental health crisis response services under section 256B.0624. In order to enroll as providers of these services, Indian health services and agencies operated by Indian tribes must meet the vendor of medical care requirements in section 256B.02, subdivision 7.

History: *2002 c 275 s 7; 1Sp2003 c 14 art 4 s 23*

256B.85 COMMUNITY FIRST SERVICES AND SUPPORTS.

Subdivision 1. **Basis and scope.** (a) Upon federal approval, the commissioner shall establish a medical assistance state plan option for the provision of home and community-based personal assistance service and supports called "community first services and supports (CFSS)."

(b) CFSS is a participant-controlled method of selecting and providing services and supports that allows the participant maximum control of the services and supports. Participants may choose the degree to which they direct and manage their supports by choosing to have a significant and meaningful role in the management of services and supports including by directly employing support workers with the necessary supports to perform that function.

(c) CFSS is available statewide to eligible individuals to assist with accomplishing activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related procedures and tasks

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through hands-on assistance to accomplish the task or constant supervision and cueing to accomplish the task; and to assist with acquiring, maintaining, and enhancing the skills necessary to accomplish ADLs, IADLs, and health-related procedures and tasks. CFSS allows payment for certain supports and goods such as environmental modifications and technology that are intended to replace or decrease the need for human assistance.

(d) Upon federal approval, CFSS will replace the personal care assistance program under sections 256.476, 256B.0625, subdivisions 19a and 19c, and 256B.0659.

Subd. 2. **Definitions.** (a) For the purposes of this section, the terms defined in this subdivision have the meanings given.

(b) "Activities of daily living" or "ADLs" means eating, toileting, grooming, dressing, bathing, mobility, positioning, and transferring.

(c) "Agency-provider model" means a method of CFSS under which a qualified agency provides services and supports through the agency's own employees and policies. The agency must allow the participant to have a significant role in the selection and dismissal of support workers of their choice for the delivery of their specific services and supports.

(d) "Behavior" means a description of a need for services and supports used to determine the home care rating and additional service units. The presence of Level I behavior is used to determine the home care rating. "Level I behavior" means physical aggression towards self or others or destruction of property that requires the immediate response of another person. If qualified for a home care rating as described in subdivision 8, additional service units can be added as described in subdivision 8, paragraph (f), for the following behaviors:

(1) Level I behavior;

(2) increased vulnerability due to cognitive deficits or socially inappropriate behavior; or

(3) increased need for assistance for participants who are verbally aggressive or resistive to care so that time needed to perform activities of daily living is increased.

(e) "Budget model" means a service delivery method of CFSS that allows the use of a service budget and assistance from a financial management services (FMS) contractor for a participant to directly employ support workers and purchase supports and goods.

(f) "Complex health-related needs" means an intervention listed in clauses (1) to (8) that has been ordered by a physician, and is specified in a community support plan, including:

(1) tube feedings requiring:

(i) a gastrojejunostomy tube; or

(ii) continuous tube feeding lasting longer than 12 hours per day;

(2) wounds described as:

(i) stage III or stage IV;

(ii) multiple wounds;

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(iii) requiring sterile or clean dressing changes or a wound vac; or

(iv) open lesions such as burns, fistulas, tube sites, or ostomy sites that require specialized care;

(3) parenteral therapy described as:

(i) IV therapy more than two times per week lasting longer than four hours for each treatment; or

(ii) total parenteral nutrition (TPN) daily;

(4) respiratory interventions, including:

(i) oxygen required more than eight hours per day;

(ii) respiratory vest more than one time per day;

(iii) bronchial drainage treatments more than two times per day;

(iv) sterile or clean suctioning more than six times per day;

(v) dependence on another to apply respiratory ventilation augmentation devices such as BiPAP and CPAP; and

(vi) ventilator dependence under section 256B.0652;

(5) insertion and maintenance of catheter, including:

(i) sterile catheter changes more than one time per month;

(ii) clean intermittent catheterization, and including self-catheterization more than six times per day; or

(iii) bladder irrigations;

(6) bowel program more than two times per week requiring more than 30 minutes to perform each time;

(7) neurological intervention, including:

(i) seizures more than two times per week and requiring significant physical assistance to maintain safety; or

(ii) swallowing disorders diagnosed by a physician and requiring specialized assistance from another on a daily basis; and

(8) other congenital or acquired diseases creating a need for significantly increased direct hands-on assistance and interventions in six to eight activities of daily living.

(g) "Community first services and supports" or "CFSS" means the assistance and supports program under this section needed for accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks through hands-on assistance to accomplish the task or constant supervision and cueing to accomplish the task, or the purchase of goods as defined in subdivision 7, clause (3), that replace the need for human assistance.

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(h) "Community first services and supports service delivery plan" or "service delivery plan" means a written document detailing the services and supports chosen by the participant to meet assessed needs that are within the approved CFSS service authorization amount. Services and supports are based on the community support plan identified in section 256B.0911 and coordinated services and support plan and budget identified in section 256B.0915, subdivision 6, if applicable, that is determined by the participant to meet the assessed needs, using a person-centered planning process.

(i) "Consultation services" means a Minnesota health care program enrolled provider organization that is under contract with the department and has the knowledge, skills, and ability to assist CFSS participants in using either the agency-provider model under subdivision 11 or the budget model under subdivision 13.

(j) "Critical activities of daily living" means transferring, mobility, eating, and toileting.

(k) "Dependency" in activities of daily living means a person requires hands-on assistance or constant supervision and cueing to accomplish one or more of the activities of daily living every day or on the days during the week that the activity is performed; however, 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 assistance needed is the assistance appropriate for a typical child of the same age.

(l) "Extended CFSS" means CFSS services and supports included in a service plan through one of the home and community-based services waivers and as approved and authorized under sections 256B.0915; 256B.092, subdivision 5; and 256B.49, which exceed the amount, duration, and frequency of the state plan CFSS services for participants.

(m) "Financial management services contractor or vendor" or "FMS contractor" means a qualified organization required for participants using the budget model under subdivision 13 that has a written contract with the department to provide vendor fiscal/employer agent financial management services (FMS). Services include but are not limited to: filing and payment of federal and state payroll taxes on behalf of the participant; initiating criminal background checks; billing for approved CFSS services with authorized funds; monitoring expenditures; accounting for and disbursing CFSS funds; providing assistance in obtaining and filing for liability, workers' compensation, and unemployment coverage; and providing participant instruction and technical assistance to the participant in fulfilling employer-related requirements in accordance with Section 3504 of the Internal Revenue Code and related regulations and interpretations, including Code of Federal Regulations, title 26, section 31.3504-1.

(n) "Health-related procedures and tasks" means procedures and tasks related to the specific needs of an individual that can be taught or assigned by a state-licensed health care or mental health professional and performed by a support worker.

(o) "Instrumental activities of daily living" means activities related to living independently in the community, including but not limited to: meal planning, preparation, and cooking; shopping for food, clothing, or other essential items; laundry; housecleaning; assistance with medications; managing finances; communicating needs and preferences during activities; arranging supports; and assistance with traveling around and participating in the community.

(p) "Legal representative" means parent of a minor, a court-appointed guardian, or another representative with legal authority to make decisions about services and supports for the participant. Other representatives with legal authority to make decisions include but are not limited to a health care agent or an attorney-in-fact authorized through a health care directive or power of attorney.

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(q) "Medication assistance" means providing verbal or visual reminders to take regularly scheduled medication, and includes any of the following supports listed in clauses (1) to (3) and other types of assistance, except that a support worker may not determine medication dose or time for medication or inject medications into veins, muscles, or skin:

(1) under the direction of the participant or the participant's representative, bringing medications to the participant including medications given through a nebulizer, opening a container of previously set-up medications, emptying the container into the participant's hand, opening and giving the medication in the original container to the participant, or bringing to the participant liquids or food to accompany the medication;

(2) organizing medications as directed by the participant or the participant's representative; and

(3) providing verbal or visual reminders to perform regularly scheduled medications.

(r) "Participant's representative" means a parent, family member, advocate, or other adult authorized by the participant to serve as a representative in connection with the provision of CFSS. This authorization must be in writing or by another method that clearly indicates the participant's free choice. The participant's representative must have no financial interest in the provision of any services included in the participant's service delivery plan and must be capable of providing the support necessary to assist the participant in the use of CFSS. If through the assessment process described in subdivision 5 a participant is determined to be in need of a participant's representative, one must be selected. If the participant is unable to assist in the selection of a participant's representative, the legal representative shall appoint one. Two persons may be designated as a participant's representative for reasons such as divided households and court-ordered custodies. Duties of a participant's representatives may include:

(1) being available while services are provided in a method agreed upon by the participant or the participant's legal representative and documented in the participant's CFSS service delivery plan;

(2) monitoring CFSS services to ensure the participant's CFSS service delivery plan is being followed; and

(3) reviewing and signing CFSS time sheets after services are provided to provide verification of the CFSS services.

(s) "Person-centered planning process" means a process that is directed by the participant to plan for services and supports. The person-centered planning process must:

(1) include people chosen by the participant;

(2) provide necessary information and support to ensure that the participant directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;

(3) be timely and occur at time and locations of convenience to the participant;

(4) reflect cultural considerations of the participant;

(5) include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning;

(6) provide the participant choices of the services and supports they receive and the staff providing those services and supports;

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(7) include a method for the participant to request updates to the plan; and

(8) record the alternative home and community-based settings that were considered by the participant.

(t) "Shared services" means the provision of CFSS services by the same CFSS support worker to two or three participants who voluntarily enter into an agreement to receive services at the same time and in the same setting by the same employer.

(u) "Support worker" means a qualified and trained employee of the agency-provider or of the participant employer under the budget model who has direct contact with the participant and provides services as specified within the participant's service delivery plan.

(v) "Wages and benefits" means the hourly wages and salaries, the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, mileage reimbursement, health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, contributions to employee retirement accounts, or other forms of employee compensation and benefits.

(w) "Worker training and development" means services for developing workers' skills as required by the participant's individual CFSS delivery plan that are arranged for or provided by the agency-provider or purchased by the participant employer. These services include training, education, direct observation and supervision, and evaluation and coaching of job skills and tasks, including supervision of health-related tasks or behavioral supports.

Subd. 3. **Eligibility.** (a) CFSS is available to a person who meets one of the following:

(1) is an enrollee of medical assistance as determined under section 256B.055, 256B.056, or 256B.057, subdivisions 5 and 9;

(2) is a participant in the alternative care program under section 256B.0913;

(3) is a waiver participant as defined under section 256B.0915, 256B.092, 256B.093, or 256B.49; or

(4) has medical services identified in a participant's individualized education program and is eligible for services as determined in section 256B.0625, subdivision 26.

(b) In addition to meeting the eligibility criteria in paragraph (a), a person must also meet all of the following:

(1) require assistance and be determined dependent in one activity of daily living or Level I behavior based on assessment under section 256B.0911; and

(2) is not a participant under a family support grant under section 252.32.

Subd. 4. **Eligibility for other services.** Selection of CFSS by a participant must not restrict access to other medically necessary care and services furnished under the state plan medical assistance benefit or other services available through alternative care.

Subd. 5. **Assessment requirements.** (a) The assessment of functional need must:

(1) be conducted by a certified assessor according to the criteria established in section 256B.0911, subdivision 3a;

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(2) be conducted face-to-face, initially and at least annually thereafter, or when there is a significant change in the participant's condition or a change in the need for services and supports, or at the request of the participant when the participant experiences a change in condition or needs a change in the services or supports; and

(3) be completed using the format established by the commissioner.

(b) The results of the assessment and any recommendations and authorizations for CFSS must be determined and communicated in writing by the lead agency's certified assessor as defined in section 256B.0911 to the participant and the agency-provider or FMS contractor chosen by the participant within 40 calendar days and must include the participant's right to appeal under section 256.045, subdivision 3.

(c) The lead agency assessor may authorize a temporary authorization for CFSS services to be provided under the agency-provider model. Authorization for a temporary level of CFSS services under the agency-provider model is limited to the time specified by the commissioner, but shall not exceed 45 days. The level of services authorized under this paragraph shall have no bearing on a future authorization. Participants approved for a temporary authorization shall access the consultation service to complete their orientation and selection of a service model.

Subd. 6. **Community first services and support service delivery plan.** (a) The CFSS service delivery plan must be developed and evaluated through a person-centered planning process by the participant, or the participant's representative or legal representative who may be assisted by a consultation services provider. The CFSS service delivery plan must reflect the services and supports that are important to the participant and for the participant to meet the needs assessed by the certified assessor and identified in the community support plan under section 256B.0911, subdivision 3, or the coordinated services and support plan identified in section 256B.0915, subdivision 6, if applicable. The CFSS service delivery plan must be reviewed by the participant, the consultation services provider, and the agency-provider or FMS contractor prior to starting services and at least annually upon reassessment, or when there is a significant change in the participant's condition, or a change in the need for services and supports.

(b) The commissioner shall establish the format and criteria for the CFSS service delivery plan.

(c) The CFSS service delivery plan must be person-centered and:

(1) specify the consultation services provider, agency-provider, or FMS contractor selected by the participant;

(2) reflect the setting in which the participant resides that is chosen by the participant;

(3) reflect the participant's strengths and preferences;

(4) include the means to address the clinical and support needs as identified through an assessment of functional needs;

(5) include individually identified goals and desired outcomes;

(6) reflect the services and supports, paid and unpaid, that will assist the participant to achieve identified goals, including the costs of the services and supports, and the providers of those services and supports, including natural supports;

(7) identify the amount and frequency of face-to-face supports and amount and frequency of remote supports and technology that will be used;

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(8) identify risk factors and measures in place to minimize them, including individualized backup plans;

(9) be understandable to the participant and the individuals providing support;

(10) identify the individual or entity responsible for monitoring the plan;

(11) be finalized and agreed to in writing by the participant and signed by all individuals and providers responsible for its implementation;

(12) be distributed to the participant and other people involved in the plan;

(13) prevent the provision of unnecessary or inappropriate care;

(14) include a detailed budget for expenditures for budget model participants or participants under the agency-provider model if purchasing goods; and

(15) include a plan for worker training and development detailing what service components will be used, when the service components will be used, how they will be provided, and how these service components relate to the participant's individual needs and CFSS support worker services.

(d) The total units of agency-provider services or the service budget amount for the budget model include both annual totals and a monthly average amount that cover the number of months of the service authorization. The amount used each month may vary, but additional funds must not be provided above the annual service authorization amount unless a change in condition is assessed and authorized by the certified assessor and documented in the community support plan, coordinated services and supports plan, and CFSS service delivery plan.

(e) In assisting with the development or modification of the plan during the authorization time period, the consultation services provider shall:

(1) consult with the FMS contractor on the spending budget when applicable; and

(2) consult with the participant or participant's representative, agency-provider, and case manager/care coordinator.

(f) The service plan must be approved by the consultation services provider for participants without a case manager/care coordinator. A case manager/care coordinator must approve the plan for a waiver or alternative care program participant.

Subd. 7. **Community first services and supports; covered services.** Within the service unit authorization or service budget amount, services and supports covered under CFSS include:

(1) assistance to accomplish activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related procedures and tasks through hands-on assistance to accomplish the task or constant supervision and cueing to accomplish the task;

(2) assistance to acquire, maintain, or enhance the skills necessary for the participant to accomplish activities of daily living, instrumental activities of daily living, or health-related tasks;

(3) expenditures for items, services, supports, environmental modifications, or goods, including assistive technology. These expenditures must:

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(i) relate to a need identified in a participant's CFSS service delivery plan;

(ii) increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance for the participant's assessed needs;

(4) observation and redirection for behavior or symptoms where there is a need for assistance. An assessment of behaviors must meet the criteria in this clause. A participant qualifies as having a need for assistance due to behaviors if the participant's behavior requires assistance at least four times per week and shows one or more of the following behaviors:

(i) physical aggression towards self or others, or destruction of property that requires the immediate response of another person;

(ii) increased vulnerability due to cognitive deficits or socially inappropriate behavior; or

(iii) increased need for assistance for participants who are verbally aggressive or resistive to care so that time needed to perform activities of daily living is increased;

(5) back-up systems or mechanisms, such as the use of pagers or other electronic devices, to ensure continuity of the participant's services and supports;

(6) services provided by a consultation services provider under contract with the department and enrolled as a Minnesota health care program provider as defined under subdivision 17;

(7) services provided by an FMS contractor under contract with the department as defined under subdivision 13;

(8) CFSS services provided by a qualified support worker who is a parent, stepparent, or legal guardian of a participant under age 18, or who is the participant's spouse. These support workers shall not provide any medical assistance home and community-based services in excess of 40 hours per seven-day period regardless of the number of parents, combination of parents and spouses, or number of children who receive medical assistance services; and

(9) worker training and development services as defined in subdivision 2, paragraph (w), and described in subdivision 18a.

Subd. 8. **Determination of CFSS service methodology.** (a) All community first services and supports must be authorized by the commissioner or the commissioner's designee before services begin, except for the assessments established in section 256B.0911. The authorization for CFSS must be completed as soon as possible following an assessment but no later than 40 calendar days from the date of the assessment.

(b) The amount of CFSS authorized must be based on the participant's home care rating described in paragraphs (d) and (e) and any additional service units for which the participant qualifies as described in paragraph (f).

(c) The home care rating shall be determined by the commissioner or the commissioner's designee based on information submitted to the commissioner identifying the following for a participant:

(1) the total number of dependencies of activities of daily living as defined in subdivision 2, paragraph (b);

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(2) the presence of complex health-related needs as defined in subdivision 2, paragraph (f); and

(3) the presence of Level I behavior as defined in subdivision 2, paragraph (d).

(d) The methodology to determine the total service units for CFSS for each home care rating is based on the median paid units per day for each home care rating from fiscal year 2007 data for the PCA program.

(e) Each home care rating is designated by the letters P through Z and EN and has the following base number of service units assigned:

(1) P home care rating requires Level I behavior or one to three dependencies in ADLs and qualifies one for five service units;

(2) Q home care rating requires Level I behavior and one to three dependencies in ADLs and qualifies one for six service units;

(3) R home care rating requires a complex health-related need and one to three dependencies in ADLs and qualifies one for seven service units;

(4) S home care rating requires four to six dependencies in ADLs and qualifies one for ten service units;

(5) T home care rating requires four to six dependencies in ADLs and Level I behavior and qualifies one for 11 service units;

(6) U home care rating requires four to six dependencies in ADLs and a complex health-related need and qualifies one for 14 service units;

(7) V home care rating requires seven to eight dependencies in ADLs and qualifies one for 17 service units;

(8) W home care rating requires seven to eight dependencies in ADLs and Level I behavior and qualifies one for 20 service units;

(9) Z home care rating requires seven to eight dependencies in ADLs and a complex health-related need and qualifies one for 30 service units; and

(10) EN home care rating includes ventilator dependency as defined in section 256B.0651, subdivision 1, paragraph (g). Participants who meet the definition of ventilator-dependent and the EN home care rating and utilize a combination of CFSS and other home care services are limited to a total of 96 service units per day for those services in combination. Additional units may be authorized when a participant's assessment indicates a need for two staff to perform activities. Additional time is limited to 16 service units per day.

(f) Additional service units are provided through the assessment and identification of the following:

(1) 30 additional minutes per day for a dependency in each critical activity of daily living as defined in subdivision 2, paragraph (j);

(2) 30 additional minutes per day for each complex health-related function as defined in subdivision 2, paragraph (f); and

(3) 30 additional minutes per day for each behavior issue as defined in subdivision 2, paragraph (d).

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(g) The service budget for budget model participants shall be based on:

(1) assessed units as determined by the home care rating; and

(2) an adjustment needed for administrative expenses.

Subd. 9. **Noncovered services.** (a) Services or supports that are not eligible for payment under this section include those that:

(1) are not authorized by the certified assessor or included in the written service delivery plan;

(2) are provided prior to the authorization of services and the approval of the written CFSS service delivery plan;

(3) are duplicative of other paid services in the written service delivery plan;

(4) supplant natural unpaid supports that appropriately meet a need in the service plan, are provided voluntarily to the participant, and are selected by the participant in lieu of other services and supports;

(5) are not effective means to meet the participant's needs; and

(6) are available through other funding sources, including, but not limited to, funding through title IV-E of the Social Security Act.

(b) Additional services, goods, or supports that are not covered include:

(1) those that are not for the direct benefit of the participant, except that services for caregivers such as training to improve the ability to provide CFSS are considered to directly benefit the participant if chosen by the participant and approved in the support plan;

(2) any fees incurred by the participant, such as Minnesota health care programs fees and co-pays, legal fees, or costs related to advocate agencies;

(3) insurance, except for insurance costs related to employee coverage;

(4) room and board costs for the participant;

(5) services, supports, or goods that are not related to the assessed needs;

(6) special education and related services provided under the Individuals with Disabilities Education Act and vocational rehabilitation services provided under the Rehabilitation Act of 1973;

(7) assistive technology devices and assistive technology services other than those for back-up systems or mechanisms to ensure continuity of service and supports listed in subdivision 7;

(8) medical supplies and equipment covered under medical assistance;

(9) environmental modifications, except as specified in subdivision 7;

(10) expenses for travel, lodging, or meals related to training the participant or the participant's representative or legal representative;

(11) experimental treatments;

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(12) any service or good covered by other medical assistance state plan services, including prescription and over-the-counter medications, compounds, and solutions and related fees, including premiums and co-payments;

(13) membership dues or costs, except when the service is necessary and appropriate to treat a health condition or to improve or maintain the participant's health condition. The condition must be identified in the participant's CFSS plan and monitored by a Minnesota health care program enrolled physician;

(14) vacation expenses other than the cost of direct services;

(15) vehicle maintenance or modifications not related to the disability, health condition, or physical need;

(16) tickets and related costs to attend sporting or other recreational or entertainment events;

(17) services provided and billed by a provider who is not an enrolled CFSS provider;

(18) CFSS provided by a participant's representative or paid legal guardian;

(19) services that are used solely as a child care or babysitting service;

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

(21) sterile procedures;

(22) giving of injections into veins, muscles, or skin;

(23) homemaker services that are not an integral part of the assessed CFSS service;

(24) home maintenance or chore services;

(25) home care services, including hospice services if elected by the participant, covered by Medicare or any other insurance held by the participant;

(26) services to other members of the participant's household;

(27) services not specified as covered under medical assistance as CFSS;

(28) application of restraints or implementation of deprivation procedures;

(29) assessments by CFSS provider organizations or by independently enrolled registered nurses;

(30) services provided in lieu of legally required staffing in a residential or child care setting; and

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

Subd. 10. **Agency-provider and FMS contractor qualifications, general requirements, and duties.** (a) Agency-providers delivering services under the agency-provider model under subdivision 11 or FMS contractors under subdivision 13 shall:

(1) enroll as a medical assistance Minnesota health care programs provider and meet all applicable provider standards and requirements;

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(2) demonstrate compliance with federal and state laws and policies for CFSS as determined by the commissioner;

(3) comply with background study requirements under chapter 245C and maintain documentation of background study requests and results;

(4) verify and maintain records of all services and expenditures by the participant, including hours worked by support workers;

(5) not engage in any agency-initiated direct contact or marketing in person, by telephone, or other electronic means to potential participants, guardians, family members, or participants' representatives;

(6) directly provide services and not use a subcontractor or reporting agent;

(7) meet the financial requirements established by the commissioner for financial solvency;

(8) have never had a lead agency contract or provider agreement discontinued due to fraud, or have never had an owner, board member, or manager fail a state or FBI-based criminal background check while enrolled or seeking enrollment as a Minnesota health care programs provider;

(9) have established business practices that include written policies and procedures, internal controls, and a system that demonstrates the organization's ability to deliver quality CFSS; and

(10) have an office located in Minnesota.

(b) In conducting general duties, agency-providers and FMS contractors shall:

(1) pay support workers based upon actual hours of services provided;

(2) pay for worker training and development services based upon actual hours of services provided or the unit cost of the training session purchased;

(3) withhold and pay all applicable federal and state payroll taxes;

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

(5) enter into a written agreement with the participant, participant's representative, or legal representative that assigns roles and responsibilities to be performed before services, supports, or goods are provided using a format established by the commissioner;

(6) report maltreatment as required under sections 626.556 and 626.557;

(7) provide the participant with a copy of the service-related rights under subdivision 20 at the start of services and supports; and

(8) comply with any data requests from the department consistent with the Minnesota Government Data Practices Act under chapter 13.

Subd. 11. **Agency-provider model.** (a) The agency-provider model includes services provided by support workers and staff providing worker training and development services who are employed by an

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agency-provider that is licensed according to chapter 245A or meets other criteria established by the commissioner, including required training.

(b) The agency-provider shall allow the participant to have a significant role in the selection and dismissal of the support workers for the delivery of the services and supports specified in the participant's service delivery plan.

(c) A participant may use authorized units of CFSS services as needed within a service authorization that is not greater than 12 months. Using authorized units in a flexible manner in either the agency-provider model or the budget model does not increase the total amount of services and supports authorized for a participant or included in the participant's service delivery plan.

(d) A participant may share CFSS services. Two or three CFSS participants may share services at the same time provided by the same support worker.

(e) The agency-provider must use a minimum of 72.5 percent of the revenue generated by the medical assistance payment for CFSS for support worker wages and benefits. The agency-provider must document how this requirement is being met. The revenue generated by the worker training and development services and the reasonable costs associated with the worker training and development services must not be used in making this calculation.

(f) The agency-provider model must be used by individuals who have been restricted by the Minnesota restricted recipient program under Minnesota Rules, parts 9505.2160 to 9505.2245.

(g) Participants purchasing goods under this model, along with support worker services, must:

(1) specify the goods in the service delivery plan and detailed budget for expenditures that must be approved by the consultation services provider or the case manager/care coordinator; and

(2) use the FMS contractor for the billing and payment of such goods.

Subd. 12. **Requirements for enrollment of CFSS agency-providers.** (a) All CFSS agency-providers must provide, at the time of enrollment, reenrollment, and revalidation as a CFSS agency-provider in a format determined by the commissioner, information and documentation that includes, but is not limited to, the following:

(1) the CFSS agency-provider's current contact information including address, telephone number, and e-mail address;

(2) proof of surety bond coverage. Upon new enrollment, or if the agency-provider's Medicaid revenue in the previous calendar year is less than or equal to $300,000, the agency-provider must purchase a surety bond of $50,000. If the agency-provider's Medicaid revenue in the previous calendar year is greater than $300,000, the agency-provider must purchase a surety bond of $100,000. The surety bond must be in a form approved by the commissioner, must be renewed annually, and must allow for recovery of costs and fees in pursuing a claim on the bond;

(3) proof of fidelity bond coverage in the amount of $20,000;

(4) proof of workers' compensation insurance coverage;

(5) proof of liability insurance;

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(6) a description of the CFSS agency-provider's organization identifying the names of all owners, managing employees, staff, board of directors, and the affiliations of the directors and owners to other service providers;

(7) a copy of the CFSS agency-provider's written policies and procedures including: hiring of employees; training requirements; service delivery; and employee and consumer safety including process for notification and resolution of consumer grievances, identification and prevention of communicable diseases, and employee misconduct;

(8) copies of all other forms the CFSS agency-provider uses in the course of daily business including, but not limited to:

(i) a copy of the CFSS agency-provider's time sheet if the time sheet varies from the standard time sheet for CFSS services approved by the commissioner, and a letter requesting approval of the CFSS agency-provider's nonstandard time sheet; and

(ii) a copy of the participant's individual CFSS service delivery plan;

(9) a list of all training and classes that the CFSS agency-provider requires of its staff providing CFSS services;

(10) documentation that the CFSS agency-provider and staff have successfully completed all the training required by this section;

(11) documentation of the agency-provider's marketing practices;

(12) disclosure of ownership, leasing, or management of all residential properties that are used or could be used for providing home care services;

(13) documentation that the agency-provider will use at least the following percentages of revenue generated from the medical assistance rate paid for CFSS services for CFSS support worker wages and benefits: 72.5 percent of revenue from CFSS providers. The revenue generated by the worker training and development services and the reasonable costs associated with the worker training and development services shall not be used in making this calculation; and

(14) documentation that the agency-provider does not burden participants' free exercise of their right to choose service providers by requiring CFSS support workers to sign an agreement not to work with any particular CFSS participant or for another CFSS agency-provider after leaving the agency and that the agency is not taking action on any such agreements or requirements regardless of the date signed.

(b) CFSS agency-providers shall provide to the commissioner the information specified in paragraph (a).

(c) All CFSS agency-providers shall require all employees in management and supervisory positions and owners of the agency who are active in the day-to-day management and operations of the agency to complete mandatory training as determined by the commissioner. Employees in management and supervisory positions and owners who are active in the day-to-day operations of an agency who have completed the required training as an employee with a CFSS agency-provider do not need to repeat the required training if they are hired by another agency, if they have completed the training within the past three years. CFSS agency-provider billing staff shall complete training about CFSS program financial management. Any new owners or employees in management and supervisory positions involved in the day-to-day operations are required to complete mandatory training as a requisite of working for the agency.

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(d) The commissioner shall send annual review notifications to agency-providers 30 days prior to renewal. The notification must:

(1) list the materials and information the agency-provider is required to submit;

(2) provide instructions on submitting information to the commissioner; and

(3) provide a due date by which the commissioner must receive the requested information.

Agency-providers shall submit the required documentation for annual review within 30 days of notification from the commissioner. If no documentation is submitted, the agency-provider enrollment number must be terminated or suspended.

Subd. 13. **Budget model.** (a) Under the budget model participants may exercise responsibility and control over the services and supports described and budgeted within the CFSS service delivery plan. Participants must use services provided by an FMS contractor as defined in subdivision 2, paragraph (m). Under this model, participants may use their approved service budget allocation to:

(1) directly employ support workers, and pay wages, federal and state payroll taxes, and premiums for workers' compensation, liability, and health insurance coverage; and

(2) obtain supports and goods as defined in subdivision 7.

(b) Participants who are unable to fulfill any of the functions listed in paragraph (a) may authorize a legal representative or participant's representative to do so on their behalf.

(c) The commissioner shall disenroll or exclude participants from the budget model and transfer them to the agency-provider model under, but not limited to, the following circumstances:

(1) when a participant has been restricted by the Minnesota restricted recipient program, in which case the participant may be excluded for a specified time period under Minnesota Rules, parts 9505.2160 to 9505.2245;

(2) when a participant exits the budget model during the participant's service plan year. Upon transfer, the participant shall not access the budget model for the remainder of that service plan year; or

(3) when the department determines that the participant or participant's representative or legal representative cannot manage participant responsibilities under the budget model. The commissioner must develop policies for determining if a participant is unable to manage responsibilities under the budget model.

(d) A participant may appeal in writing to the department under section 256.045, subdivision 3, to contest the department's decision under paragraph (c), clause (3), to disenroll or exclude the participant from the budget model.

(e) The FMS contractor shall not provide CFSS services and supports under the agency-provider service model.

(f) The FMS contractor shall provide service functions as determined by the commissioner for budget model participants that include but are not limited to:

(1) assistance with the development of the detailed budget for expenditures portion of the service delivery plan as requested by the consultation services provider or participant;

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(2) billing and making payments for budget model expenditures;

(3) assisting participants in fulfilling employer-related requirements according to section 3504 of the Internal Revenue Code and related regulations and interpretations, including Code of Federal Regulations, title 26, section 31.3504-1, which includes assistance with filing and paying payroll taxes, and obtaining worker compensation coverage;

(4) data recording and reporting of participant spending;

(5) other duties established in the contract with the department, including with respect to providing assistance to the participant, participant's representative, or legal representative in performing their employer responsibilities regarding support workers. The support worker shall not be considered the employee of the FMS contractor; and

(6) billing, payment, and accounting of approved expenditures for goods for agency-provider participants.

(g) The FMS contractor shall:

(1) not limit or restrict the participant's choice of service or support providers or service delivery models consistent with any applicable state and federal requirements;

(2) provide the participant, consultation services provider, and the case manager or care coordinator, if applicable, with a monthly written summary of the spending for services and supports that were billed against the spending budget;

(3) be knowledgeable of state and federal employment regulations, including those under the Fair Labor Standards Act of 1938, and comply with the requirements under section 3504 of the Internal Revenue Code and related regulations and interpretations, including Code of Federal Regulations, title 26, section 31.3504-1, regarding agency employer tax liability for vendor or fiscal employer agent, and any requirements necessary to process employer and employee deductions, provide appropriate and timely submission of employer tax liabilities, and maintain documentation to support medical assistance claims;

(4) have current and adequate liability insurance and bonding and sufficient cash flow as determined by the commissioner and have on staff or under contract a certified public accountant or an individual with a baccalaureate degree in accounting;

(5) assume fiscal accountability for state funds designated for the program and be held liable for any overpayments or violations of applicable statutes or rules, including but not limited to the Minnesota False Claims Act, chapter 15C; and

(6) maintain documentation of receipts, invoices, and bills to track all services and supports expenditures for any goods purchased and maintain time records of support workers. The documentation and time records must be maintained for a minimum of five years from the claim date and be available for audit or review upon request by the commissioner. Claims submitted by the FMS contractor to the commissioner for payment must correspond with services, amounts, and time periods as authorized in the participant's service budget and service plan and must contain specific identifying information as determined by the commissioner.

(h) The commissioner of human services shall:

(1) establish rates and payment methodology for the FMS contractor;

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(2) identify a process to ensure quality and performance standards for the FMS contractor and ensure statewide access to FMS contractors; and

(3) establish a uniform protocol for delivering and administering CFSS services to be used by eligible FMS contractors.

Subd. 14. **Participant's responsibilities under budget model.** (a) A participant using the budget model must use an FMS contractor or vendor that is under contract with the department. Upon a determination of eligibility and completion of the assessment and community support plan, the participant shall choose a FMS contractor from a list of eligible vendors maintained by the department.

(b) When the participant, participant's representative, or legal representative chooses to be the employer of the support worker, they are responsible for the hiring and supervision of the support worker, including but not limited to recruiting, interviewing, training, scheduling, and discharging the support worker consistent with federal and state laws and regulations.

(c) In addition to the employer responsibilities in paragraph (b), the participant, participant's representative, or legal representative is responsible for:

(1) tracking the services provided and all expenditures for goods or other supports;

(2) preparing and submitting time sheets, signed by both the participant and support worker, to the FMS contractor on a regular basis and in a timely manner according to the FMS contractor's procedures;

(3) notifying the FMS contractor within ten days of any changes in circumstances affecting the CFSS service plan or in the participant's place of residence including, but not limited to, any hospitalization of the participant or change in the participant's address, telephone number, or employment;

(4) notifying the FMS contractor of any changes in the employment status of each participant support worker; and

(5) reporting any problems resulting from the quality of services rendered by the support worker to the FMS contractor. If the participant is unable to resolve any problems resulting from the quality of service rendered by the support worker with the assistance of the FMS contractor, the participant shall report the situation to the department.

Subd. 15. **Documentation of support services provided.** (a) Support services provided to a participant by a support worker employed by either an agency-provider or the participant acting as the employer must be documented daily by each support worker, on a time sheet form approved by the commissioner. All documentation may be Web-based, electronic, or paper documentation. The completed form must be submitted on a regular basis to the provider or the participant and the FMS contractor selected by the participant to provide assistance with meeting the participant's employer obligations and kept in the participant's record.

(b) The activity documentation must correspond to the written service delivery plan and be reviewed by the agency-provider or the participant and the FMS contractor when the participant is the employer of the support worker.

(c) The time sheet must be on a form approved by the commissioner documenting time the support worker provides services to the participant. The following criteria must be included in the time sheet:

(1) full name of the support worker and individual provider number;

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(2) agency-provider name and telephone numbers, if responsible for delivery services under the written service plan;

(3) full name of the participant;

(4) consecutive dates, including month, day, and year, and arrival and departure times with a.m. or p.m. notations;

(5) signatures of the participant or the participant's representative;

(6) personal signature of the support worker;

(7) any shared care provided, if applicable;

(8) a statement that it is a federal crime to provide false information on CFSS billings for medical assistance payments; and

(9) dates and location of participant stays in a hospital, care facility, or incarceration.

Subd. 16. **Support workers requirements.** (a) Support workers shall:

(1) enroll with the department as a support worker after a background study under chapter 245C has been completed and the support worker has received a notice from the commissioner that:

(i) the support worker is not disqualified under section 245C.14; or

(ii) is disqualified, but the support worker has received a set-aside of the disqualification under section 245C.22;

(2) have the ability to effectively communicate with the participant or the participant's representative;

(3) have the skills and ability to provide the services and supports according to the participant's CFSS service delivery plan and respond appropriately to the participant's needs;

(4) not be a participant of CFSS, unless the support services provided by the support worker differ from those provided to the support worker;

(5) complete the basic standardized training as determined by the commissioner before completing enrollment. The training must be available in languages other than English and to those who need accommodations due to disabilities. Support worker training must include successful completion of the following training components: basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic roles and responsibilities of support workers including information about basic body mechanics, emergency preparedness, orientation to positive behavioral practices, orientation to responding to a mental health crisis, fraud issues, time cards and documentation, and an overview of person-centered planning and self-direction. Upon completion of the training components, the support worker must pass the certification test to provide assistance to participants;

(6) complete training and orientation on the participant's individual needs; and

(7) maintain the privacy and confidentiality of the participant, and not independently determine the medication dose or time for medications for the participant.

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(b) The commissioner may deny or terminate a support worker's provider enrollment and provider number if the support worker:

(1) lacks the skills, knowledge, or ability to adequately or safely perform the required work;

(2) fails to provide the authorized services required by the participant employer;

(3) has been intoxicated by alcohol or drugs while providing authorized services to the participant or while in the participant's home;

(4) has manufactured or distributed drugs while providing authorized services to the participant or while in the participant's home; or

(5) has been excluded as a provider by the commissioner of human services, or the United States Department of Health and Human Services, Office of Inspector General, from participation in Medicaid, Medicare, or any other federal health care program.

(c) A support worker may appeal in writing to the commissioner to contest the decision to terminate the support worker's provider enrollment and provider number.

(d) A support worker must not provide or be paid for more than 275 hours of CFSS per month, regardless of the number of participants the support worker serves or the number of agency-providers or participant employers by which the support worker is employed. The department shall not disallow the number of hours per day a support worker works unless it violates other law.

Subd. 16a. **Exception to support worker requirements for continuity of services.** The support worker for a participant may be allowed to enroll with a different CFSS agency-provider or FMS contractor upon initiation, rather than completion, of a new background study according to chapter 245C, if the following conditions are met:

(1) the commissioner determines that the support worker's change in enrollment or affiliation is needed to ensure continuity of services and protect the health and safety of the participant;

(2) the chosen agency-provider or FMS contractor has been continuously enrolled as a CFSS agency-provider or FMS contractor for at least two years or since the inception of the CFSS program, whichever is shorter;

(3) the participant served by the support worker chooses to transfer to the CFSS agency-provider or the FMS contractor to which the support worker is transferring;

(4) the support worker has been continuously enrolled with the former CFSS agency-provider or FMS contractor since the support worker's last background study was completed; and

(5) the support worker continues to meet requirements of subdivision 16, excluding paragraph (a), clause (1).

Subd. 17. **Consultation services description and duties.** (a) Consultation services means providing assistance to the participant in making informed choices regarding CFSS services in general, and self-directed tasks in particular, and in developing a person-centered service delivery plan to achieve quality service outcomes.

(b) Consultation services is a required service that may include but is not limited to:

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(1) an initial and annual orientation to CFSS information and policies, including selecting a service model;

(2) assistance with the development, implementation, management, and evaluation of the person-centered service delivery plan;

(3) consultation on recruiting, selecting, training, managing, directing, evaluating, and supervising support workers;

(4) reviewing the use of and access to informal and community supports, goods, or resources;

(5) assistance with fulfilling responsibilities and requirements of CFSS, including modifying service delivery plans and changing service models; and

(6) assistance with accessing FMS contractors or agency-providers.

(c) Duties of a consultation services provider shall include but are not limited to:

(1) review and finalization of the CFSS service delivery plan by the consultation services provider organization;

(2) distribution of copies of the final service delivery plan to the participant and to the agency-provider or FMS contractor, case manager/care coordinator, and other designated parties;

(3) an evaluation of services upon receiving information from an FMS contractor indicating spending or participant employer concerns;

(4) a semiannual review of services if the participant does not have a case manager/care coordinator and when the support worker is a paid parent of a minor participant or the participant's spouse;

(5) collection and reporting of data as required by the department; and

(6) providing the participant with a copy of the service-related rights under subdivision 20 at the start of consultation services.

Subd. 17a. **Consultation services provider qualifications and requirements.** The commissioner shall develop the qualifications and requirements for providers of consultation services under subdivision 17. These providers must satisfy at least the following qualifications and requirements:

(1) are under contract with the department;

(2) are not the FMS contractor as defined in subdivision 2, paragraph (m), the CFSS or home and community-based services waiver agency-provider or vendor to the participant, or a lead agency;

(3) meet the service standards as established by the commissioner;

(4) employ lead professional staff with a minimum of three years of experience in providing support planning, support broker, or consultation services and consumer education to participants using a self-directed program using FMS under medical assistance;

(5) are knowledgeable about CFSS roles and responsibilities including those of the certified assessor, FMS contractor, agency-provider, and case manager/care coordinator;

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(6) comply with medical assistance provider requirements;

(7) understand the CFSS program and its policies;

(8) are knowledgeable about self-directed principles and the application of the person-centered planning process;

(9) have general knowledge of the FMS contractor duties and participant employment model, including all applicable federal, state, and local laws and regulations regarding tax, labor, employment, and liability and workers' compensation coverage for household workers; and

(10) have all employees, including lead professional staff, staff in management and supervisory positions, and owners of the agency who are active in the day-to-day management and operations of the agency, complete training as specified in the contract with the department.

Subd. 18. **Service unit and budget allocation requirements and limits.** (a) For the agency-provider model, services will be authorized in units of service. The total service unit amount must be established based upon the assessed need for CFSS services, and must not exceed the maximum number of units available as determined under subdivision 8.

(b) For the budget model, the service budget allocation allowed for services and supports is defined in subdivision 8, paragraph (g).

Subd. 18a. **Worker training and development services.** (a) The commissioner shall develop the scope of tasks and functions, service standards, and service limits for worker training and development services.

(b) Worker training and development services are in addition to the participant's assessed service units or service budget. Services provided according to this subdivision must:

(1) help support workers obtain and expand the skills and knowledge necessary to ensure competency in providing quality services as needed and defined in the participant's service delivery plan;

(2) be provided or arranged for by the agency-provider under subdivision 11 or purchased by the participant employer under the budget model under subdivision 13; and

(3) be described in the participant's CFSS service delivery plan and documented in the participant's file.

(c) Services covered under worker training and development shall include:

(1) support worker training on the participant's individual assessed needs, condition, or both, provided individually or in a group setting by a skilled and knowledgeable trainer beyond any training the participant or participant's representative provides;

(2) tuition for professional classes and workshops for the participant's support workers that relate to the participant's assessed needs, condition, or both;

(3) direct observation, monitoring, coaching, and documentation of support worker job skills and tasks, beyond any training the participant or participant's representative provides, including supervision of health-related tasks or behavioral supports that is conducted by an appropriate professional based on the participant's assessed needs. These services must be provided within 14 days of the start of services or the start of a new support worker except as provided in paragraph (d) and must be specified in the participant's service delivery plan; and

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(4) reporting service and support concerns to the appropriate provider.

(d) The services in paragraph (c), clause (3), are not required to be provided for a new support worker providing services for a participant due to staffing failures, unless the support worker is expected to provide ongoing backup staffing coverage.

(e) Worker training and development services shall not include:

(1) general agency training, worker orientation, or training on CFSS self-directed models;

(2) payment for preparation or development time for the trainer or presenter;

(3) payment of the support worker's salary or compensation during the training;

(4) training or supervision provided by the participant, the participant's support worker, or the participant's informal supports, including the participant's representative; or

(5) services in excess of 96 units per annual service authorization, unless approved by the department.

Subd. 19. **Support system.** (a) The commissioner shall provide information, consultation, training, and assistance to ensure the participant is able to manage the services and supports and budgets, if applicable. This support shall include individual consultation on how to select and employ workers, manage responsibilities under CFSS, and evaluate personal outcomes.

(b) The commissioner shall provide assistance with the development of risk management agreements.

Subd. 20. **Service-related rights.** (a) Participants must be provided with adequate information, counseling, training, and assistance, as needed, to ensure that the participant is able to choose and manage services, models, and budgets. This support shall include information regarding:

(1) person-centered planning;

(2) the range and scope of individual choices;

(3) the process for changing plans, services, and budgets;

(4) the grievance process;

(5) individual rights;

(6) identifying and assessing appropriate services;

(7) risks and responsibilities; and

(8) risk management.

(b) The commissioner must ensure that the participant has a copy of the most recent community support plan and service delivery plan.

(c) A participant who appeals a reduction in previously authorized CFSS services may continue previously authorized services pending an appeal in accordance with section 256.045.

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(d) If the units of service or budget allocation for CFSS are reduced, denied, or terminated, the commissioner must provide notice of the reasons for the reduction in the participant's notice of denial, termination, or reduction.

(e) If all or part of a service delivery plan is denied approval, the commissioner must provide a notice that describes the basis of the denial.

Subd. 21. **Development and Implementation Council.** The commissioner shall establish a Development and Implementation Council of which the majority of members are individuals with disabilities, elderly individuals, and their representatives. The commissioner shall consult and collaborate with the council when developing and implementing this section for at least the first five years of operation. The commissioner, in consultation with the council, shall provide recommendations on how to improve the quality and integrity of CFSS, reduce the paper documentation required in subdivisions 10, 12, and 15, make use of electronic means of documentation and online reporting in order to reduce administrative costs, and improve training to the legislative chairs of the health and human services policy and finance committees by February 1, 2014.

Subd. 22. **Quality assurance and risk management system.** (a) The commissioner shall establish quality assurance and risk management measures for use in developing and implementing CFSS, including those that (1) recognize the roles and responsibilities of those involved in obtaining CFSS, and (2) ensure the appropriateness of such plans and budgets based upon a recipient's resources and capabilities. Risk management measures must include background studies and backup and emergency plans, including disaster planning.

(b) The commissioner shall provide ongoing technical assistance and resource and educational materials for CFSS participants.

(c) Performance assessment measures, such as a participant's satisfaction with the services and supports, and ongoing monitoring of health and well-being shall be identified in consultation with the council established in subdivision 21.

(d) Data reporting requirements will be developed in consultation with the council established in subdivision 21.

Subd. 23. **Commissioner's access.** When the commissioner is investigating a possible overpayment of Medicaid funds, the commissioner must be given immediate access without prior notice to the agency-provider or FMS contractor's office during regular business hours and to documentation and records related to services provided and submission of claims for services provided. Denying the commissioner access to records is cause for immediate suspension of payment and terminating the agency provider's enrollment according to section 256B.064 or terminating the FMS contract.

Subd. 24. **CFSS agency-providers; background studies.** CFSS agency-providers enrolled to provide CFSS services under the medical assistance program shall comply with the following:

(1) owners who have a five percent interest or more and all managing employees are subject to a background study as provided in chapter 245C. This applies to currently enrolled CFSS agency-providers and those agencies seeking enrollment as a CFSS agency-provider. "Managing employee" has the same meaning as Code of Federal Regulations, title 42, section 455. An organization is barred from enrollment if:

(i) the organization has not initiated background studies on owners managing employees; or

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(ii) the organization has initiated background studies on owners and managing employees, but the commissioner has sent the organization a notice that an owner or managing employee of the organization has been disqualified under section 245C.14, and the owner or managing employee has not received a set-aside of the disqualification under section 245C.22;

(2) a background study must be initiated and completed for all staff who will have direct contact with the participant to provide worker training and development; and

(3) a background study must be initiated and completed for all support workers.

Subd. 25. **Commissioner recommendations required.** In consultation with the Development and Implementation Council described in subdivision 21 and other stakeholders, the commissioner shall develop recommendations for revisions to subdivisions 12, 15, and 16 that promote self-direction in the following areas:

(1) CFSS provider and support worker enrollment, qualification, and disqualification criteria;

(2) documentation requirements that are consistent with state and federal requirements; and

(3) provisions to maintain program integrity and assure fiscal accountability for goods and services purchased through CFSS.

The recommendations shall be provided to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services policy and finance by November 15, 2013.

History: *2013 c 108 art 7 s 49; 2014 c 275 art 1 s 69-71,140; 2014 c 291 art 10 s 6; 2014 c 312 art 26 s 4-23*

NOTE: This section, as added by Laws 2013, chapter 108, article 7, section 49, is effective upon federal approval but no earlier than April 1, 2014. The service will begin 90 days after federal approval. The commissioner of human services shall notify the revisor of statutes when this occurs. Laws 2013, chapter 108, article 7, section 49, the effective date, as amended by Laws 2014, chapter 312, article 26, section 24.

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