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*

256B.011 MS 2022 [Repealed, 2023 c 70 art 4 s 113]

256B.0185 MS 2012 [Repealed, 2013 c 107 art 4 s 22]

256B.02 DEFINITIONS.

Subdivision 1. MS 1986 [Repealed, 1987 c 363 s 14]

Subd. 2. MS 1986 [Repealed, 1987 c 363 s 14]

Subd. 3. MS 1986 [Repealed, 1987 c 363 s 14]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 services or supplies provided or prescribed by persons authorized by state law to give such services and supplies. The term includes, but is not limited to, directors and officers of corporations or members of partnerships who, either individually or jointly with another or others, have the legal control, supervision, or responsibility of submitting claims for reimbursement to the medical assistance program. The term only includes directors and officers of corporations who personally receive a portion of the distributed assets upon liquidation or dissolution, and their liability is limited to the portion of the claim that bears the same proportion to the total claim as their share of the distributed assets bears to the total distributed assets.

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

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

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]

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 this chapter or chapter 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 a condition:

(1) that is found to be closely related to a developmental disability, including but not limited to cerebral palsy, epilepsy, autism, fetal alcohol spectrum disorder, and Prader-Willi syndrome; and

(2) that meets all of the following criteria:

(i) is severe and chronic;

(ii) results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with developmental disabilities;

(iii) requires treatment or services similar to those required for persons with developmental disabilities;

(iv) is manifested before the person reaches 22 years of age;

(v) is likely to continue indefinitely;

(vi) results in substantial functional limitations in three or more of the following areas of major life activity:

(A) self-care;

(B) understanding and use of language;

(C) learning;

(D) mobility;

(E) self-direction; or

(F) capacity for independent living; and

(vii) is not attributable to mental illness as defined in section 245.462, subdivision 20, or 245.4871, subdivision 15. For purposes of this item, notwithstanding section 245.462, subdivision 20, or 245.4871, subdivision 15, "mental illness" does not include autism or other pervasive developmental disorders.

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.

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.

Subd. 20. **Fraud.** "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in an unauthorized benefit to the person or another person or an act, promise to act, or omission made with the intent to obtain a benefit in a manner that is prohibited. Fraud includes:

(1) submitting an application for provider status knowing that the application misrepresents, conceals, or fails to disclose any material information;

(2) intentionally submitting a claim for reimbursement under this chapter, knowing or having reason to know the claim is ineligible for reimbursement in whole or in part;

(3) providing documentation or other information requested by the commissioner having knowledge that it is false in any material respect; and

(4) any act that constitutes the commission, or attempt or conspiracy to commit, a violation of any of the following:

(i) section 256.98 (wrongfully obtaining assistance);

(ii) section 609.466 (medical assistance fraud);

(iii) section 609.48 (perjury), involving making a false statement related to medical assistance or the receipt of public money;

(iv) section 609.496 (concealing criminal proceeds) or 609.497 (engaging in business of concealing criminal proceeds), involving proceeds consisting of public money;

(v) section 609.52 (theft), involving theft of property consisting of public money;

(vi) section 609.542 (illegal remuneration);

(vii) section 609.625 (aggravated forgery) or 609.63 (forgery), involving falsely filing any record, account, or other document with any state agency or department or falsely making or altering any record, account, or other document filed with any state agency or department;

(viii) section 609.821 (financial transaction card fraud), involving a public assistance benefit;

(ix) a felony listed in United States Code, title 42, section 1320a-7b(b)(1) or (2), subject to any safe harbors established in Code of Federal Regulations, title 42, section 1001.952; and

(x) any other act that constitutes fraud under applicable federal law.

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; 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; 2016 c 158 art 2 s 74; 2017 c 40 art 1 s 64; 1Sp2019 c 9 art 2 s 111; 2024 c 125 art 1 s 11; 2024 c 127 art 46 s 11; 2025 c 38 art 8 s 56; 2026 c 121 art 4 s 25*

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 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;

(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;

(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;

(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. MS 2013 Supp [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. MS 1998 [Repealed, 2000 c 449 s 15]

Subd. 3. **Tribal purchasing model.** (a) Notwithstanding subdivision 1 and section 256B.0625, the commissioner may make payments to federally recognized Indian Tribes with a reservation in the state to provide medical assistance 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 program, 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.

[See Note.]

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; 2016 c 158 art 2 s 75*

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 MS 2008 [Repealed, 2009 c 173 art 3 s 26]

256B.032 MS 2009 Supp [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 and MinnesotaCare program recipients. The commissioner may enter into risk-based and non-risk-based contracts. The commissioner must not enter into a contract with a health maintenance organization, as defined in section 62D.02, which is not a nonprofit corporation organized under chapter 317A or a local governmental unit, as defined in section 62D.02. Contracts may be for the full range of health services, or a portion thereof, for medical assistance 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; 2016 c 158 art 2 s 76; 2024 c 127 art 57 s 55*

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 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 and, if applicable, MinnesotaCare 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 medical assistance 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 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.

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 or 256B.69.

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; 2016 c 158 art 2 s 77,78*

256B.0371 PERFORMANCE BENCHMARKS FOR DENTAL ACCESS; CONTINGENT DENTAL ADMINISTRATOR.

Subdivision 1. **Benchmark for dental access.** For coverage years 2022 to 2024, the commissioner shall establish a performance benchmark under which at least 55 percent of children and adults who were continuously enrolled for at least 11 months in either medical assistance or MinnesotaCare through a managed care or county-based purchasing plan received at least one dental visit during the coverage year.

Subd. 2. **Corrective action plan.** For coverage years 2022 to 2024, if a managed care or county-based purchasing plan under contract with the commissioner to provide dental services under this chapter or chapter 256L has a rate of dental utilization that is ten percent or more below the performance benchmark specified in subdivision 1, the commissioner shall require the managed care or county-based purchasing plan to submit a corrective action plan to the commissioner describing how the entity intends to increase dental utilization to meet the performance benchmark. The managed care or county-based purchasing plan must:

(1) provide a written corrective action plan to the commissioner for approval;

(2) implement the plan; and

(3) provide the commissioner with documentation of each corrective action taken.

Subd. 3. **Contingent contract with dental administrator.** (a) The commissioner shall determine the extent to which managed care and county-based purchasing plans in the aggregate meet the performance benchmark specified in subdivision 1 for coverage year 2024. If managed care and county-based purchasing plans in the aggregate fail to meet the performance benchmark, the commissioner, after issuing a request for information followed by a request for proposals, shall contract with a dental administrator to administer dental services beginning January 1, 2028, for recipients of medical assistance and MinnesotaCare who are served under fee-for-service and persons receiving services through managed care plans.

(b) The dental administrator must provide administrative services, including but not limited to:

(1) provider recruitment, contracting, and assistance;

(2) recipient outreach and assistance;

(3) utilization management and reviews of medical necessity for dental services;

(4) dental claims processing;

(5) coordination of dental care with other services;

(6) management of fraud and abuse;

(7) monitoring access to dental services statewide;

(8) performance measurement;

(9) quality improvement and evaluation;

(10) management of third-party liability requirements; and

(11) establishment of grievance and appeals processes for providers and enrollees that the commissioner can monitor.

(c) Dental administrator payments to contracted dental providers must be based on rates recommended by the dental access working group. If the recommended rates are not established in law prior to July 1, 2027, dental administrator payments to contracted dental providers must be at the rates established under sections 256B.76 and 256L.11.

(d) Recipients must be given a choice of dental provider, including any provider who agrees to provider participation requirements and payment rates established by the commissioner and dental administrator. The dental administrator must comply with the network adequacy and geographic access requirements that apply to managed care plans for dental services under section 62K.14.

(e) The contract with the dental administrator must include performance benchmarks, accountability measures, and progress rewards based on the recommendations from the dental access working group.

(f) Notwithstanding the contract term limits under section 16C.06, subdivision 3b, the commissioner may extend the implementation contract for the single dental administrator under paragraph (a) up to three years from the date of execution and may contract with the same contractor as the single dental administrator for up to five years, beginning in 2028.

Subd. 4. **Dental utilization report.** (a) The commissioner shall submit an annual report beginning March 15, 2022, and ending March 15, 2026, to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance that includes the percentage for adults and children one through 20 years of age for the most recent complete calendar year receiving at least one dental visit for both fee-for-service and the prepaid medical assistance program. The report must include:

(1) statewide utilization for both fee-for-service and for the prepaid medical assistance program;

(2) utilization by county;

(3) utilization by children receiving dental services through fee-for-service and through a managed care plan or county-based purchasing plan; and

(4) utilization by adults receiving dental services through fee-for-service and through a managed care plan or county-based purchasing plan.

(b) The report must also include a description of any corrective action plans required to be submitted under subdivision 2.

(c) The initial report due on March 15, 2022, must include the utilization metrics described in paragraph (a) for each of the following calendar years: 2017, 2018, 2019, and 2020.

(d) In the annual report due on March 15, 2023, and in each report due thereafter, the commissioner shall include the following:

(1) the number of dentists enrolled with the commissioner as a medical assistance dental provider and the congressional district or districts in which the dentist provides services;

(2) the number of enrolled dentists who provided fee-for-service dental services to medical assistance or MinnesotaCare patients within the previous calendar year in the following increments: one to nine patients, ten to 100 patients, and over 100 patients;

(3) the number of enrolled dentists who provided dental services to medical assistance or MinnesotaCare patients through a managed care plan or county-based purchasing plan within the previous calendar year in the following increments: one to nine patients, ten to 100 patients, and over 100 patients; and

(4) the number of dentists who provided dental services to a new patient who was enrolled in medical assistance or MinnesotaCare within the previous calendar year.

(e) The report due on March 15, 2023, must include the metrics described in paragraph (d) for each of the following years: 2017, 2018, 2019, 2020, and 2021.

History: *1Sp2021 c 7 art 1 s 2; 2022 c 55 art 1 s 128; 2022 c 98 art 2 s 3; 1Sp2025 c 3 art 8 s 6*

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 chapter 256S; waivered services under community access for disability inclusion 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 section 256B.0625, subdivision 8; occupational therapy services under section 256B.0625, subdivision 8a; speech-language therapy services under Minnesota Rules, part 9505.0390; respiratory therapy services under Minnesota Rules, part 9505.0295; physician services under section 256B.0625, subdivision 3; dental services under section 256B.0625, subdivision 9; alternative care services under section 256B.0913; adult residential program grants under section 245.73; 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; 2015 c 78 art 6 s 31; 2016 c 158 art 1 s 109; art 2 s 79; 2019 c 54 art 2 s 15*

256B.039 MS 2006 [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 Minnesota for the provision of early and periodic screening, diagnosis, and treatment administrative services for American Indian children, according to section 256B.0625, subdivision 58, and Code of Federal Regulations, title 42, section 441, subpart B, 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. 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; a full account of all pre-enrollment, postenrollment, and unannounced site visits to providers under section 256B.044, subdivision 5; 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, 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.** The commissioner must 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 reasonable or medically necessary, or false statement or representation of material facts by a vendor of medical care. The commissioner may use both prepayment and postpayment review systems to review claims submitted by vendors. Payment of claims, including payments made after a prepayment review, does not prohibit the commissioner from completing a postpayment claims review and taking additional administrative actions or monetary recovery against a vendor. 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. MS 1996 [Repealed, 1997 c 7 art 2 s 67]

Subd. 12. **Limitation on services.** (a) The commissioner shall 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; and

(2) reimbursement of public and private nonprofit providers serving the population with a disability 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. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

(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. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

(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. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

(d) Effective July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance, the commissioner shall 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.

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.

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;

(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; and

(ix) allergen-reducing products as described in section 256B.0625, subdivision 67, paragraph (c) or (d);

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

(6) drugs; and

(7) quitline services as described in section 256B.0625, subdivision 68, paragraph (c).

This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

(b) Effective July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance, 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;

(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; and

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

(5) nonemergency medical transportation; and

(6) drugs.

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

(d) The commissioner may not utilize volume purchase through competitive bidding and negotiation under the provisions of chapter 16C for special transportation services or incontinence products and related supplies. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

(e) Effective July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance, the commissioner must not utilize volume purchase through competitive bidding and negotiation under the provisions of chapter 16C for incontinence products and related supplies.

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, an advanced practice registered nurse, 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 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) The commissioner must 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. Unless otherwise provided by law, 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. MS 2012 [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.

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 website, 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.** The commissioner shall enroll providers and conduct screening activities as required by Code of Federal Regulations, title 42, section 455, subpart E, and sections 256B.044 to 256B.0448.

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 the fee described in paragraph (b), or a request for a hardship exception as described in the specified procedures. The 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.

(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.

(c) The 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.** (a) 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). This paragraph expires upon the effective date of paragraph (b).

(b) Effective January 1, 2028, or upon federal approval, whichever is later, 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.0618, paragraph (b).

Subd. 24. **Medicaid waiver requests and state plan amendments; notice; public comments.** (a) The commissioner shall notify the chairs and ranking minority members of the legislative committees with jurisdiction over medical assistance at least 30 days before submitting a new Medicaid waiver request to the federal government.

(b) 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 website 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 publish the text of all public comments on the agency's website and consider public comments when preparing the final waiver request or state plan amendment that is to be submitted to the federal government for approval.

(c) The commissioner shall also publish on the agency's website 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.

Subd. 24a. **Medicaid waiver requests and state plan amendments; prohibited actions.** Without prior legislative authorization under subdivision 24b, the commissioner must not take the following actions:

(1) terminate a medical assistance program, waiver, or benefit; or

(2) request federal assistance with terminating a medical assistance program, waiver, or benefit.

Subd. 24b. **Medicaid waiver requests and state plan amendments; legislative authorization.** (a) The commissioner must notify the chairs and ranking minority members of the standing committees of the house of representatives and senate with jurisdiction over medical assistance policy and finance at least 60 days prior to taking one of the actions listed under subdivision 24a.

(b) Upon notification, the standing committees of the house of representatives and senate with jurisdiction over medical assistance policy and finance must schedule a hearing on the proposed action within 30 days of notification.

(c) If all of the standing committees of the house of representatives and senate with jurisdiction over medical assistance policy and finance vote to advise the commissioner that a proposed action should not be implemented as proposed, the commissioner must not implement the proposed action until the legislature adjourns the annual legislative session that began after the vote of the committees. A committee vote under this subdivision must be by a majority of the committee.

Subd. 25. **Medical assistance and MinnesotaCare payment increase.** (a) The commissioner shall increase medical assistance and MinnesotaCare fee-for-service payments by an amount equal to the tax rate defined for hospitals, surgical centers, or health care providers under sections 295.50 to 295.57 for all services subject to those taxes.

(b) The commissioner shall reflect in the total payments made to managed care organizations, county-based purchasing plans, and other participating entities contracted with the commissioner under section 256B.69, the cost of: (1) payments made to providers for the tax on the services outlined in paragraph (a); and (2) the taxes imposed under sections 297I.05, subdivision 5, and 256.9657, subdivision 3, on premium revenue paid by the state for medical assistance and the MinnesotaCare program. Any increase based on clause (2) must be reflected in provider rates paid by the managed care organization, county-based purchasing plan, or other participating entity, unless the managed care organization, county-based purchasing plan, or other participating entity is a staff model health plan company.

Subd. 26. **Notice of employed persons with disabilities program.** At the time of initial enrollment and at least annually thereafter, the commissioner shall provide information on the medical assistance program for employed persons with disabilities under section 256B.057, subdivision 9, to all medical assistance enrollees who indicate they have a disability.

Subd. 27. **Disenrollment under medical assistance and MinnesotaCare.** (a) The commissioner shall regularly obtain and use information from reliable data sources, including but not limited to managed care and county-based purchasing plans, state health and human services programs, mail returned by the United States Postal Service with a forwarding address, and the National Change of Address database maintained by the United States Postal Service, to update mailing addresses and other contact information for medical assistance and MinnesotaCare enrollees.

(b) The commissioner shall not disenroll an individual from medical assistance or MinnesotaCare in cases of returned mail until the commissioner makes at least two attempts by phone, email, or other methods to contact the individual. The commissioner may disenroll the individual after providing no less than 30 days for the individual to respond to the most recent contact attempt.

Subd. 28. **Medical assistance education program.** (a) The commissioner must provide information to all medical assistance enrollees on the following topics:

(1) an enrollee's benefits, rights, and responsibilities under medical assistance;

(2) how to appropriately access and receive services under medical assistance;

(3) an enrollee's right to file complaints, grievances, and appeals;

(4) general information about preventing fraud and abuse in the medical assistance program; and

(5) how to report concerns to the department and managed care organizations about fraud and abuse in the medical assistance program.

(b) The commissioner must ensure that the information provided under this subdivision:

(1) is in plain language;

(2) is culturally and linguistically appropriate; and

(3) complies with applicable federal Medicaid requirements for communicating with enrollees.

(c) When an enrollee's use of medical assistance results in abusive or fraudulent billing, the commissioner must notify the enrollee about the availability of the information under this subdivision and may provide additional educational information targeted to the event that resulted in abusive or fraudulent billing.

(d) The commissioner may require entities participating in medical assistance, including but not limited to managed care organizations, providers, lead agencies, and Tribal agencies, to assist in delivering the information required under this subdivision.

(e) For enrollees who receive case management services or have a support plan developed under section 256B.0911, the information required under this subdivision must be tailored to their service needs and may be delivered through the support planning process by the lead agency or managed care organization, as appropriate.

Subd. 29. **Interpretive guidelines for disability waiver regulation.** (a) The commissioner must develop and publish interpretive guidelines within 120 calendar days of the effective date of any statutory changes, waiver plan amendments, state or federal administrative rulings, or state or federal court decisions that affect policies or reimbursement for services licensed under chapter 245D, authorized under section 256B.092 or 256B.49, or reimbursed under section 256B.4914.

(b) Interpretive guidelines issued by the commissioner under this subdivision do not have the force and effect of law and have no precedential effect but may be relied on by consumers, providers of service, county agencies, the Department of Human Services, and others concerned until revoked or modified. An interpretive guideline may be expressly revoked or modified by the commissioner or by the issuance of another interpretive guideline but may not be revoked or modified retroactively to the detriment of consumers, providers of service, county agencies, the Department of Human Services, or others concerned. A change in the law or an interpretation of the law occurring after the interpretive guidelines are issued, whether in the form of a

statute, court decision, administrative ruling, or subsequent interpretive guideline, results in the revocation or modification of the previously adopted guidelines to the extent that the change affects the guidelines.

[See Note.]

Subd. 30. **Certified assessor team.** The commissioner must employ certified assessors within the department to conduct assessments under section 256B.0911 on behalf of lead agencies under conditions and circumstances determined by the commissioner. Certified assessors employed by the commissioner may conduct assessments in addition to other duties as assigned, except the certified assessors employed by the commissioner must not perform any responsibilities of a lead agency described in section 256B.0911 other than assessments. Nothing in this subdivision creates an obligation for the commissioner to provide the department's certified assessors to conduct assessments on behalf of a lead agency.

[See Note.]

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; 2016 c 158 art 2 s 80; 2017 c 40 art 1 s 121; 1Sp2017 c 6 art 4 s 16,17; 1Sp2019 c 9 art 2 s 112; art 7 s 14-17; 2020 c 115 art 4 s 110; 7Sp2020 c 1 art 6 s 25; 1Sp2021 c 7 art 1 s 3; 2023 c 25 s 136; 2023 c 61 art 3 s 2; 2023 c 70 art 1 s 8; art 16 s 10; art 17 s 40; 1Sp2025 c 3 art 8 s 7,8; art 17 s 8; 1Sp2025 c 9 art 6 s 6; art 7 s 7; 2026 c 88 art 1 s 118; 2026 c 95 art 4 s 12; art 9 s 3-5; 2026 c 121 art 3 s 14-16; art 4 s 26; art 6 s 12; art 9 s 11,12; 2026 c 127 art 6 s 3*

NOTE: Subdivision 29, as added by Laws 2026, chapter 121, article 9, section 11, is effective July 1, 2028, and applies to statutory changes, waiver plan amendments, state or federal administrative rulings, or state or federal court decisions effective or issued on or after that date. Laws 2026, chapter 121, article 9, section 11, the effective date.

NOTE: Subdivision 30, as added by Laws 2026, chapter 121, article 9, section 12, is effective July 1, 2027. Laws 2026, chapter 121, article 9, section 12, the effective date.

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.

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. MS 2008 [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 and 256L.12 and Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 4, paragraph (c); children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; nursing facilities under the alternative payment demonstration project under section 256B.434; and county-based purchasing entities under section 256B.692.

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

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

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

Subd. 3. **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 and 256L.12 and Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 4, paragraph (c); 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 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; 2016 c 158 art 2 s 81,82*

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 Advisory Council 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 and MinnesotaCare programs; and shall make related legislative recommendations as appropriate. The commissioner shall post the recommendations required under this subdivision on agency websites.

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, advanced practice registered nurses, 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; 2016 c 158 art 2 s 83; 2020 c 115 art 4 s 111; 2021 c 30 art 1 s 24*

256B.0437 PRE-ENROLLMENT ASSESSMENT.

(a) Before enrolling a provider or agency, the commissioner may complete a pre-enrollment risk assessment of the provider or agency seeking to enroll to confirm the provider or agency's eligibility and the provider or agency's ability to meet the requirements of this chapter. The commissioner must utilize a

risk-score framework as a component of the assessment that identifies service-specific fraud risk indicators, including but not limited to organizational readiness, financial stability, compliance history, and addressing service necessity.

(b) Based on the assessment of fraud risk indicators described in paragraph (a), the commissioner may deem the applicant ineligible and deny or rescind enrollment. The decision to deny or rescind enrollment must be made in writing and sent using a signature-verified confirmed delivery method. An applicant may request reconsideration of the decision regarding the applicant's eligibility in writing within 30 business days after the date the notice was issued. The commissioner must notify each applicant of the commissioner's final decision regarding the applicant's eligibility.

(c) A provider enrolled before July 1, 2026, that billed for services on or after January 1, 2025, must receive a positive pre-enrollment risk assessment no later than July 1, 2027, to remain eligible. A provider or agency enrolled before July 1, 2026, that has not billed for services on or after January 1, 2025, must receive a positive pre-enrollment risk assessment no later than July 1, 2026, to remain eligible. A provider that becomes ineligible under this paragraph regains eligibility after receiving a positive assessment under this section if the provider remains otherwise eligible.

History: *2026 c 121 art 3 s 17*

256B.044 PROVIDER ENROLLMENT.

Subdivision 1. **Designating categorical risk levels.** (a) The commissioner must designate provider types as "limited-risk," "moderate-risk," 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 commissioner must publish a list of provider types and designated categorical risk levels in the Minnesota Health Care Program Provider Manual.

(b) The list and criteria are not subject to the requirements under chapter 14 and section 14.386 does not apply.

(c) The commissioner's designations are not subject to administrative appeal.

Subd. 2. **Required verifications and checks.** The commissioner must perform the following verifications and checks prior to making an enrollment determination and periodically thereafter:

(1) verify that the provider meets applicable federal and state requirements for the provider type;

(2) conduct license verifications, as applicable, including verification of current licensure in Minnesota and in any other state in which the provider is or was previously licensed, in accordance with Code of Federal Regulations, title 42, section 455.412;

(3) conduct database checks on a pre-enrollment and postenrollment basis to ensure that the provider continues to meet the enrollment criteria for the provider type, in accordance with Code of Federal Regulations, title 42, section 455.436;

(4) confirm that the provider and any disclosed owners, managing employees, or controlling individuals are not excluded from participation in any state's Medicaid program, Medicare, or any other federal health care program;

(5) verify the provider's National Provider Identifier and, as applicable, Medicare enrollment status;

(6) verify the provider's tax identification number and business registration status;

(7) verify the provider's ownership and control disclosures as required under federal law; and

(8) conduct any additional screenings, verifications, or reviews that are necessary to protect the integrity of the medical assistance program or that are required under federal law.

Subd. 3. **Required background studies.** (a) The commissioner must conduct a background study under chapter 245C for a provider applying for enrollment. The background study must include a review of databases in section 245C.08, subdivision 1, paragraph (a), clauses (1) to (5), and any other databases required under federal law.

(b) The commissioner must conduct a background study under this subdivision for each individual with an ownership or control interest in, or who is an officer, director, agent, managing employee, or other person with operational or managerial control of, the provider.

(c) Fingerprint-based studies are required when mandated by federal law or when a provider is designated moderate-risk or high-risk under subdivision 1.

(d) The commissioner may conduct background studies postenrollment as necessary.

(e) A provider's failure to submit to the commissioner the information required for a background study under this subdivision is grounds for denial or termination of enrollment in medical assistance.

(f) A provider's enrollment must be denied or terminated if a provider or individual subject to a background study under this subdivision is disqualified under chapter 245C or is excluded from participating in any federal health care programs.

Subd. 4. **Service location enrollment.** (a) A provider must enroll each provider-controlled location where direct services are provided. "Provider-controlled location" means a physical site owned, leased, operated, or otherwise controlled by the provider.

(b) Separate enrollment is not required for services provided in a recipient's home or community setting, telehealth services delivered from an enrolled site, compliant mobile services, or other federally permissible exemptions.

(c) A provider's failure to enroll each provider-controlled location where direct services are provided is grounds for sanctions under section 256B.064.

Subd. 5. **Required on-site inspections.** (a) As a condition of enrollment in medical assistance, the commissioner shall require that a provider designated as moderate-risk or high-risk by CMS or the commissioner permit CMS, CMS's agents, or CMS's designated contractors and the state agency, the state agency's agents, or the state agency's designated contractors to conduct unannounced on-site inspections of any provider location.

(b) Consistent with the commissioner's authority under Code of Federal Regulations, title 42, section 455.452, prior to enrolling, prior to reenrolling, and prior to revalidating a provider designated as moderate-risk or high-risk, the commissioner must conduct unannounced on-site inspections of all provider locations.

Subd. 6. **Surety bonds.** (a) The commissioner must require a provider to purchase a surety bond as a condition of initial enrollment, reenrollment, revalidation, reinstatement, or continued enrollment. Upon new enrollment, or if the provider's medical assistance revenue in the previous calendar year is less than or equal to $300,000, the provider must purchase a surety bond of $50,000. If the provider's medical assistance revenue in the previous calendar year is greater than $300,000, the provider must purchase a surety bond of $100,000. The surety bond must name the Department of Human Services as an obligee, must be purchased

new annually, and must allow for recovery of costs and fees in pursuing a claim on the bond. Any action to obtain monetary recovery or sanctions from a surety bond must occur within six years from the date the debt is affirmed by a final agency decision. An agency decision is final when the right to appeal the debt has been exhausted or the time to appeal has expired under section 256B.064.

(b) This subdivision does not apply if the provider currently maintains a surety bond under the requirements under section 256B.0659, 256B.0701, or 256B.85.

Subd. 7. **Financial capacity.** As a condition of enrolling in medical assistance, the commissioner must require, in a form and manner prescribed by the commissioner, that a provider attest to sufficient financial capacity to operate.

Subd. 8. **Compliance programs.** (a) The commissioner may require, as a condition of enrollment in medical assistance, that a provider in a particular industry, of a particular provider type, or with a particular risk categorization under subdivision 1, establish and maintain a compliance program consistent with federal program integrity guidance issued by CMS or the United States Department of Health and Human Services Office of Inspector General.

(b) If an enrolled provider is required by the commissioner or by federal or state law to designate an individual as the provider's compliance officer, the provider must appoint an individual responsible for implementing and overseeing the compliance program.

(c) At a minimum, the compliance program must include policies and procedures designed to:

(1) ensure adherence to federal and state laws and program requirements governing medical assistance and prevent the submission of improper claims;

(2) train employees, agents, contractors, and subcontractors, including billing personnel, on applicable federal and state laws and program requirements;

(3) establish procedures for receiving, investigating, and responding to allegations of improper conduct and for implementing corrective actions;

(4) use auditing, monitoring, or other evaluation techniques to assess ongoing compliance;

(5) promptly report to the commissioner any credible evidence of violations of federal and state laws or regulations governing medical assistance; and

(6) report and return identified medical assistance overpayments within 60 days after discovery or by the date any corresponding cost report is due, whichever is later, in accordance with federal law.

Subd. 9. **Incomplete provider enrollment applications.** The commissioner may deny a provider's incomplete enrollment application if a provider fails to respond to the commissioner's request for additional information within 60 days of the request.

Subd. 10. **Correspondence and notifications.** The commissioner may deliver correspondence and notifications, including notifications of termination and other actions, electronically to a provider's MN-ITS mailbox. This subdivision does not apply to correspondence and notifications related to background studies.

History: *2026 c 121 art 3 s 18*

256B.0441 PROVIDER REVALIDATION.

Subdivision 1. **Requirement.** The commissioner must revalidate each enrolled provider according to this section.

Subd. 2. **Schedule.** (a) The commissioner shall revalidate:

(1) each provider at least once every five years;

(2) each personal care assistance agency, community first services and supports (CFSS) provider-agency, and CFSS financial management services provider at least once every three years;

(3) each early intensive developmental and behavioral intervention agency at least once every three years; and

(4) each medical-assistance-only provider type the commissioner deems high-risk under section 256B.044, subdivision 1, at least every three years.

(b) The commissioner must conduct revalidation of a provider more frequently when required under federal law or when necessary to protect program integrity.

Subd. 3. **Procedures.** (a) The commissioner shall conduct revalidation as follows:

(1) provide 30 days' notice to the provider of the provider's revalidation due date, including instructions for revalidation, a list of materials the provider must submit, and a notice about the possibility of an unannounced site visit as required under paragraph (b);

(2) if a provider fails to submit all required materials or satisfy the requirements of paragraph (b) by the due date, notify the provider of the deficiency within 14 days after the due date and allow the provider an additional 14 days from the notification date to comply; and

(3) if a provider fails to remedy a deficiency within the additional 28-day time period, give 15 days' notice of termination and immediately suspend the provider's ability to bill. The commissioner's decision to suspend the provider's ability to bill is not subject to an administrative appeal.

(b) For a provider designated moderate-risk or high-risk, the commissioner must conduct unannounced site visits at each of the provider's enrolled locations under section 256B.044, subdivision 4, no more than 30 days prior to the provider's revalidation due date.

(c) A provider must demonstrate financial capacity, as described under section 256B.044, subdivision 7, as a requirement of revalidation under this subdivision.

History: *2026 c 121 art 3 s 19*

256B.0442 PROVIDER ENROLLMENT SUSPENSIONS AND TERMINATIONS.

Subdivision 1. **Suspension of billing privileges.** (a) If a provider fails to comply with any individual provider requirement or condition of participation, the commissioner may suspend the provider's ability to bill until the provider comes into compliance.

(b) Notwithstanding any law to the contrary, the commissioner may immediately impose a suspension under this subdivision when necessary to protect public funds or ensure program integrity.

(c) A suspension under this subdivision does not limit the authority of the commissioner to issue any other sanction authorized under federal or state law.

(d) The commissioner's decision to suspend a provider's ability to bill is not subject to an administrative appeal.

Subd. 2. **Revocation for lack of documentation.** (a) 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 the 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.

(b) Nothing in this subdivision limits the authority of the commissioner to sanction a provider under section 256B.064.

Subd. 3. **Mandatory denial or termination of enrollment.** (a) The commissioner must terminate or deny the enrollment of a provider when:

(1) an individual with a five percent or greater direct or indirect ownership interest in the provider does not submit timely and accurate information and cooperate with the screening methods required under section 256B.044;

(2) an individual with a five percent or greater direct or indirect ownership interest in the provider has been convicted of a criminal offense related to the individual's involvement in Medicare, Medicaid, or the Children's Health Insurance Program in the last ten years, unless the commissioner determines that denial or termination of enrollment is not in the best interests of the medical assistance program and the commissioner documents that determination in writing;

(3) the provider, or an individual with a five percent or greater direct or indirect ownership interest in the provider, was terminated from participation in Medicare on or after January 1, 2011, or under a Medicaid program or Children's Health Insurance Program of any other state, and is currently included in the termination database under Code of Federal Regulations, title 42, section 455.417, except as provided in paragraph (b);

(4) the provider, or an individual with a five percent or greater direct or indirect ownership interest in the provider, fails to submit timely or accurate information, unless the commissioner determines that termination or denial of enrollment is not in the best interests of the medical assistance program and the commissioner documents that determination in writing;

(5) the provider, or an individual with a five percent or greater direct or indirect ownership interest in the provider, fails to submit sets of fingerprints in a form and manner determined by the commissioner within 30 days of a request from the Centers for Medicare and Medicaid Services (CMS) or the commissioner, unless the commissioner determines that termination or denial of enrollment is not in the best interests of the medical assistance program and the commissioner documents that determination in writing;

(6) the provider fails to permit access to provider locations for any site visits under section 256B.044, subdivision 5, unless the commissioner determines that termination or denial of enrollment is not in the best interests of the medical assistance program and the commissioner documents that determination in writing; or

(7) CMS or the commissioner determines that the provider has falsified any information provided on the application or cannot verify the identity of any provider applicant.

(b) The commissioner may exempt a rehabilitation agency from termination or denial that would otherwise be required under paragraph (a), clause (3), if the agency:

(1) is unable to retain Medicare certification and enrollment solely due to a lack of billing to the Medicare program;

(2) meets all other applicable Medicare certification requirements based on an on-site review completed by the commissioner of health; and

(3) serves primarily a pediatric population.

Subd. 4. **Termination for lack of submitted claims.** The commissioner may terminate the enrollment of an individual provider or an entity provider if the individual provider or entity provider has not submitted any claims in the previous 12 consecutive calendar months.

History: *2026 c 121 art 3 s 20*

256B.0443 PROVIDER PAYMENT WITHHOLDS.

(a) If the commissioner or the Centers for Medicare and Medicaid Services designates a provider type as high-risk under section 256B.044, subdivision 1, the commissioner may withhold payment from providers within that category upon initial enrollment for a 90-day period.

(b) The withholding for each provider must begin on the date of the first submission of a claim.

History: *2026 c 121 art 3 s 21*

256B.0444 ENROLLMENT MORATORIUM FOR HIGH-RISK PROVIDERS.

Subdivision 1. **Provider enrollment moratorium.** (a) If the commissioner or the Centers for Medicare and Medicaid Services (CMS) designates a provider type as high-risk under section 256B.044, subdivision 1, the commissioner may issue a statewide or regional enrollment moratorium and stop accepting and processing applications from providers within that category within 30 days of the date of the designation or upon federal approval of the moratorium, whichever is later. A moratorium issued under this section is effective for a period of up to 24 months from the date the moratorium is issued.

(b) Before ending the moratorium under this section, the commissioner must revalidate the enrollment of each provider within the affected category in accordance with the revalidation procedures under section 256B.0441, subdivision 3.

Subd. 2. **Moratorium exceptions.** The commissioner may grant exceptions to a moratorium issued under subdivision 1 and must make publicly available the processes and criteria the commissioner will use to grant exceptions. The commissioner may grant an exception if a county or Tribal agency submits a request for an exception to the commissioner.

Subd. 3. **Continued enrollment of new clients.** Nothing in this section prohibits an enrolled provider subject to a moratorium under this section from enrolling new clients or beneficiaries during the period of the enrollment moratorium.

Subd. 4. **Notice.** (a) At least ten days prior to issuing an enrollment moratorium under this section, the commissioner must notify enrolled providers within the affected category and the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services about the actions the commissioner plans to take under this section. The notice must:

(1) include a list of provider types to which the moratorium applies;

(2) provide a general explanation for the basis of the high-risk designation; and

(3) identify the start dates and anticipated durations of the enrollment moratorium.

(b) Within 60 days of ending an enrollment moratorium under this section, the commissioner must notify the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services about the results of the moratorium.

History: *2026 c 121 art 3 s 22*

256B.0445 ADDITIONAL PROVIDER ENROLLMENT REQUIREMENTS FOR SPECIFIC PROVIDER TYPES.

Subdivision 1. **Durable medical equipment provider or supplier.** (a) For the purposes of this subdivision, "durable medical equipment provider or supplier" means a medical supplier that can purchase medical equipment or supplies for sale or rent to the general public and is able to perform or arrange for necessary repairs to and maintenance of equipment offered for sale or rent.

(b) Upon initial enrollment, reenrollment, and notification of revalidation, all durable medical equipment, prosthetics, orthotics, and supplies medical suppliers meeting the durable medical equipment provider or supplier definition in paragraph (a), operating in Minnesota, and receiving medical assistance money must purchase a surety bond that is annually renewed, designates the state agency as the obligee, and is submitted in a form approved by the commissioner. For purposes of this paragraph, 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.

(c) At the time of initial enrollment or reenrollment, durable medical equipment providers or suppliers as defined in paragraph (a) must purchase a surety bond of $50,000. If a revalidating provider's medical assistance 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 medical assistance 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 be purchased new annually and must allow for recovery of costs and fees in pursuing a claim on the bond. Any action to obtain monetary recovery or sanctions from a surety bond must occur within six years from the date the debt is affirmed by a final agency decision. An agency decision is final when the right to appeal the debt has been exhausted or the time to appeal has expired under section 256B.064.

Subd. 2. **Providers licensed by the commissioner of human services.** An enrolled provider that is licensed by the commissioner under chapter 245A must designate an individual as the licensee's compliance officer under section 256B.044, subdivision 8, paragraph (b).

Subd. 3. **Providers licensed by the commissioner of health.** An enrolled provider that is licensed by the commissioner of health as a home care provider under chapter 144A with a home and community-based services designation under section 144A.484 on the home care license, or as an assisted living facility under chapter 144G, must designate an individual as the licensee's compliance officer under section 256B.044, subdivision 8, paragraph (b).

History: *2026 c 121 art 3 s 23*

256B.0446 ADDITIONAL PROVIDER ENROLLMENT TRAINING REQUIREMENTS FOR HIGH-RISK PROVIDERS.

Subdivision 1. **Applicability.** This section applies to any agency that provides a service designated by the commissioner as high-risk under section 256B.044, subdivision 1. For purposes of this section, "agency" means the legal entity that is applying to be or is enrolled with Minnesota health care programs as a medical assistance provider according to Minnesota Rules, part 9505.0195.

Subd. 2. **Mandatory compliance training.** (a) Effective January 1, 2027, before applying for enrollment or reenrollment as a medical assistance provider, an agency applying to provide services designated by the commissioner as high-risk under section 256B.044, subdivision 1, must require all owners of the agency who are active in the day-to-day management and operations of the agency and all managerial and supervisory employees to complete compliance training. All individuals required to complete training under this subdivision must repeat the training prior to the agency's revalidation as a medical assistance provider.

(b) New owners active in day-to-day management and operations of the agency and new managerial and supervisory employees of the agency must complete compliance training under this subdivision within 30 calendar days of becoming an owner of or beginning employment with the agency and prior to conducting any management or operations activities for the agency. If an individual moves to another agency providing the same service and serves in a similar ownership or employment capacity, the individual is not required to repeat the training required under this subdivision. If the individual does not repeat the compliance training, the individual must provide documentation to the agency that proves that the individual completed the compliance training within the provider revalidation schedule for the relevant provider type as determined by the commissioner under section 256B.0441, subdivisions 2 and 3.

(c) The commissioner must determine the format and content of the compliance training. The training must include the following topics, adapted as necessary for each provider type subject to the requirements of this subdivision:

(1) state and federal program billing, documentation, and service delivery requirements;

(2) enrollment requirements;

(3) provider program integrity, including fraud prevention, detection, and penalties;

(4) fair labor standards;

(5) workplace safety requirements; and

(6) recent changes in service requirements.

History: *2026 c 121 art 3 s 24*

256B.0447 ENHANCED PREPAYMENT REVIEW.

Subdivision 1. **Purpose and authority.** The commissioner must conduct enhanced prepayment review of submitted fee-for-service medical assistance claims to ensure compliance with state and federal law and prevent improper payments.

Subd. 2. **Review requirement.** Beginning April 1, 2027, the commissioner must conduct enhanced prepayment review under this section of at least 65 percent of all fee-for-service claims.

Subd. 3. **Notice.** (a) Except as provided in paragraph (b), the commissioner must provide written notice to a provider placed under enhanced prepayment review at least 15 days before the review is implemented. The notice must include:

(1) the basis for the review;

(2) the effective date of the review; and

(3) the standards the commissioner will use to determine when the provider, covered service, or claims will no longer be subject to enhanced prepayment review.

(b) The commissioner may delay, limit, or withhold notice to a provider if providing notice would compromise program integrity, prejudice an audit or investigation, or conflict with federal law or federal guidance.

Subd. 4. **Continued enrollment of new clients.** Nothing in this section prohibits an enrolled provider that is subject to enhanced prepayment review from enrolling new clients or beneficiaries during the period of review unless otherwise prohibited by law or by a separate action of the commissioner.

Subd. 5. **Timely claims processing.** The commissioner must administer enhanced prepayment review in a manner consistent with Code of Federal Regulations, title 42, section 447.45.

Subd. 6. **Relationship to other actions.** Enhanced prepayment review under this section does not preclude the commissioner from conducting a preliminary investigation, full investigation, payment suspension, postpayment review, audit, overpayment recovery, sanction, or referral to law enforcement under this chapter or under applicable federal law.

Subd. 7. **Information on website.** At least annually, the commissioner must publish information on enhanced prepayment review on the Department of Human Services website. The information must include, at minimum, the list of covered services subject to review and aggregate outcomes, including claim denials, payments delayed, and referrals for further action.

History: *2026 c 121 art 3 s 25*

256B.0448 POSTPAYMENT REVIEW.

Subdivision 1. **Purpose and authority.** The commissioner may conduct postpayment review of claims, encounters, cost reports, rate submissions, and other billings submitted for payment or reimbursement under this chapter to identify improper payments and recover payments made in violation of state or federal law or program requirements.

Subd. 2. **Scope of review.** The commissioner may conduct postpayment review on a claim-by-claim basis or through other review methods authorized by state or federal law.

Subd. 3. **Provider obligations.** (a) A provider subject to postpayment review must maintain documentation necessary to support claims, encounters, cost reports, rate submissions, other billings submitted for payment or reimbursement under this chapter, and compliance with program requirements.

(b) The commissioner may require a provider to submit records or supporting documentation relevant to a postpayment review.

(c) A provider's failure to provide requested records or supporting documentation to the commissioner according to the timeline specified by the commissioner may result in recovery of payments or sanctions under section 256B.064 and other applicable laws.

Subd. 4. **Recovery and sanctions.** If postpayment review identifies an overpayment or other noncompliance with medical assistance payment requirements, the commissioner may recover payments and impose sanctions in accordance with section 256B.064 and other applicable laws.

Subd. 5. **Relationship to other actions.** Conducting postpayment review of a provider under this section does not preclude the commissioner from conducting a preliminary investigation, full investigation, enhanced prepayment review, payment suspension, audit, overpayment recovery, sanction, or referral to law enforcement under this chapter or applicable federal law.

History: *2026 c 121 art 3 s 26*

256B.045 CONTINUITY OF CARE.

Subdivision 1. **Definitions.** (a) For purposes of this section and section 256B.046, the following terms have the meanings given.

(b) "Administrative action" means an action undertaken by the commissioner to sanction a provider or obtain monetary recovery under section 256B.064, suspend or revoke a provider's license under section 245A.07, or initiate a payment withhold under section 245.095 or 256B.064.

(c) "Complex transition" means that a recipient, without intensive transition planning and coordination, is likely to experience or has experienced an avoidable hospitalization, institutionalization, serious clinical deterioration, or loss of housing as a result of an administrative action or serious operational event.

(d) "Lead agency" means the county, Tribe, or managed care organization responsible for administering medical assistance to a recipient.

(e) "Recipient" means an enrollee, participant, resident, or other individual receiving community residential services, family residential services, customized living, 24-hour customized living, integrated community supports, residential substance use disorder treatment services, or residential mental health treatment services under medical assistance.

(f) "Serious operational event" means insolvency, receivership, bankruptcy, abandonment, inability of a provider to safely operate, or any other circumstances disrupting a provider's ability to continue to provide services or operate a service setting.

Subd. 2. **Provider duties.** (a) If a medical assistance service provider determines it is unable to continue to provide services to a recipient due to a serious operational event, the provider must:

(1) notify each recipient; each recipient's responsible party, if applicable; the lead agency; and the commissioner as soon as possible but no later than 30 days before terminating services to each recipient;

(2) fully cooperate with the commissioner and lead agency in supporting each recipient in transitioning to another provider of each recipient's choice; and

(3) provide each recipient with a copy of the relevant recipient bill of rights or recipient protections, if applicable, as soon as possible but no later than 30 days before terminating services.

(b) Nothing in this section absolves a provider of its obligations under chapters 144A, 144G, 245A, 245D, 245G, and 245I with respect to service suspensions, service terminations, contract terminations, and coordinated moves. The commissioner of health, the commissioner of human services, or both, may impose any sanctions available under law for violations of state statute or a licensing requirement even if the provider complies with this section and section 256B.046.

Subd. 3. **Lead agency duties.** (a) When a provider is subject to an administrative action or serious operational event, the lead agency must:

(1) inform the appropriate ombudsperson's office for each recipient currently receiving services, if applicable, that the recipient's service provider is subject to an administrative action or is experiencing a serious operational event; and

(2) directly notify each recipient who receives services from the provider that the recipient's service provider is subject to an administrative action or is experiencing a serious operational event.

(b) When a service provider provides notice under subdivision 2 that it is unable to continue to provide services to a recipient due to an administrative action or serious operational event, the lead agency must assist the provider in developing a continuity of care plan to facilitate the recipient's transition to another provider of the recipient's choice. The continuity of care plan must be developed through a person-centered process and include alternative service options, settings, and service providers with known service capacity. The lead agency must complete and receive approval from the recipient of the continuity of care plan no later than 14 days following the notification under subdivision 2.

(c) When a lead agency identifies a recipient's transition as a complex transition under section 256B.046, the lead agency must develop a complex transition plan and cooperate with and provide information to the commissioner as requested so that the commissioner can ensure each recipient receives continuity of medically necessary services and supports through a safe and orderly transition to an appropriate alternative service provider.

(d) Nothing in this section prohibits the lead agency from contacting the commissioner or continuity of care team established in subdivision 4 to request support in ensuring continuity of care.

Subd. 4. **Commissioner's duties.** (a) When the commissioner takes an administrative action against a provider, the commissioner must endeavor to contact the lead agency administering services for potentially affected recipients as soon as practicable and no later than 30 days prior to the administrative action becoming effective. The commissioner must ensure that the lead agency is taking appropriate steps to ensure continuity of care and that the affected recipients will:

(1) continue to receive needed medically necessary services and supports;

(2) be given free choice of service, service setting, and service provider if the recipient transfers to another service, service setting, or service provider; and

(3) secure safe and stable housing.

(b) The commissioner must establish and maintain a continuity of care team to support continuity of care efforts by lead agencies and providers. The continuity of care team must include personnel from across the Department of Human Services with roles in monitoring and supporting providers and lead agencies, establishing standards for continuity of care, supporting transition planning processes for individuals with a complex transition designation, and overseeing licensing and program integrity efforts. The commissioner

may include personnel from other state agencies and housing support providers necessary to effectively carry out the duties of the continuity of care team.

(c) The continuity of care team must provide support, oversight, and direction to lead agencies and providers when a recipient's transition is identified as a complex transition under section 256B.046.

(d) Nothing in this section prohibits the continuity of care team from providing support to lead agencies, providers, and recipients on continuity of care efforts not covered by this section or section 256B.046.

History: *2026 c 121 art 1 s 1*

256B.046 COMPLEX TRANSITIONS.

Subdivision 1. **Complex transition identification.** (a) The lead agency must work with the provider and commissioner to identify each recipient whose transition is a complex transition. The lead agency and provider must submit to the commissioner a complex transition plan as described in subdivision 2 for each recipient identified under this paragraph.

(b) The commissioner may establish objective thresholds to create a presumption of complex transition based on the number of recipients affected by a serious operational event or administrative action, recipient acuity, service type, or unresolved discharge or placement barriers.

Subd. 2. **Complex transition plan.** (a) The commissioner must develop guidance on effective complex transition planning and make a complex transition plan template available to providers and lead agencies. The plan template must include data fields to collect at least the following information:

(1) recipient's name and acuity level;

(2) stabilization actions to be taken to prevent gaps in care and housing;

(3) names, contact information, and known capacity of alternative providers;

(4) transition timelines, transportation, and handoff procedures;

(5) a communication plan for each recipient, the recipient's family, and the recipient's guardian, if applicable, including language access; and

(6) steps to be taken to coordinate with lead agencies, case managers, and ombudsperson offices, when applicable.

(b) Providers and lead agencies must use the plan template described in paragraph (a) to develop a complex transition plan for each recipient whose transition is identified as a complex transition.

Subd. 3. **Complex transition planning.** (a) A lead agency that receives notice from a provider of a serious operational event must assist a recipient with an identified complex transition to develop a complex transition plan through a person-centered process. The complex transition plan must include alternative service options, service settings, service providers with known service capacity, and safe and stable housing options. Within 14 days of receiving notice from a provider of a serious operational event, the lead agency must ensure completion and approval of the complex transition plan by the recipient or the recipient's representative.

(b) A lead agency that receives notice from the commissioner of an administrative action must assist a recipient with an identified complex transition to develop a complex transition plan through a person-centered process. The complex transition plan must include alternative service options, service settings, service

providers with known service capacity, and safe and stable housing options. Within 14 days of receiving notice from the commissioner of an administrative action, other than notice of actions necessary to protect the health and safety of a recipient, the lead agency must ensure completion and approval of the complex transition plan by the recipient or the recipient's representative. For any administrative action necessary to protect the health and safety of a recipient, the lead agency must immediately take all necessary actions to ensure the health and safety of the recipient.

(c) Lead agencies must, as soon as possible, convene a meeting of representatives of the recipient; the recipient's representative, if appropriate; the lead agency; the provider, if the commissioner determines the provider's participation is appropriate; and the commissioner to discuss implementation of the complex transition plan.

(d) While a complex transition plan is active, lead agencies must convene every 14 days for a status meeting to provide a progress report to the commissioner on implementation of the complex transition plan.

Subd. 4. **No alternative services notification.** (a) If the lead agency does not identify an alternative service option, service setting, service provider, or safe and stable housing option, the lead agency must notify the commissioner and the commissioner of health, if applicable.

(b) Upon receiving a notification from the lead agency that the lead agency has failed to arrange for an alternative service option, service setting, service provider, or safe and stable housing option as required under the complex transition plan, the commissioner must determine if:

(1) there exists a good cause under Code of Federal Regulations, title 42, section 455.23(e) or (f), to not suspend payments under section 256B.064, subdivision 2;

(2) a delay in the implementation date of an administrative action is needed to support complex transition planning under this section; or

(3) there is cause to petition the district court in Ramsey County under section 245A.13 to be appointed receiver to operate a residential program.

Subd. 5. **Publishing data on continuity of care planning and complex transitions.** (a) The commissioner must maintain on the Department of Human Services' website a dashboard sharing data on the:

(1) number of active continuity of care plans;

(2) number of recipients included in an active continuity of care plan;

(3) average time between approval of a continuity of care plan and closure of that plan;

(4) number of active complex transition plans;

(5) number of complex transition plans completed before the provider ceases providing services or closes a setting, on an annual basis;

(6) number of complex transition plans completed after the provider ceases providing services or closes a setting, on an annual basis;

(7) number of complex transition plans that were not successfully completed, on an annual basis;

(8) number of notifications received by lead agencies under subdivision 3, paragraph (a); and

(9) number of notifications received by lead agencies under subdivision 3, paragraph (b).

(b) The commissioner must include functionality within the dashboard to filter data by region or county, provided the filtering functionalities comply with federal or state laws regarding the protection of personal health information and personally identifiable information.

History: *2026 c 121 art 1 s 2*

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 (o).

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. MS 1986 [Repealed, 1987 c 403 art 2 s 164]

Subd. 5. **Obligation of local agency to process medical assistance applications within established timelines.** (a) 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.

(b) A local agency must notify the commissioner within five calendar days when the local agency fails to meet at least 80 percent of the local agency's monthly application and redetermination deadlines.

Subd. 6. **Authority to intervene.** Upon receiving a notice from a local agency pursuant to subdivision 5, paragraph (b), the commissioner may provide support to the local agency to timely process the local agency's outstanding applications and redeterminations.

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; 2015 c 78 art 4 s 61; 2026 c 127 art 6 s 4,5*

256B.051 Subdivision 1. MS 2024 [Repealed, 2026 c 95 art 4 s 42]

Subd. 2. MS 2025 Supp [Repealed, 2026 c 95 art 4 s 42]

Subd. 3. MS 2025 Supp [Repealed, 2026 c 95 art 4 s 42]

Subd. 4. MS 2024 [Repealed, 2026 c 95 art 4 s 42]

Subd. 5. MS 2025 Supp [Repealed, 2026 c 95 art 4 s 42]

Subd. 6. MS 2025 Supp [Repealed, 2026 c 95 art 4 s 42]

Subd. 6a. MS 2025 Supp [Repealed, 2026 c 95 art 4 s 42]

Subd. 6b. MS 2025 Supp [Repealed, 2026 c 95 art 4 s 42]

Subd. 7. MS 2024 [Repealed, 2026 c 95 art 4 s 42]

Subd. 8. MS 2025 Supp [Repealed, 2026 c 95 art 4 s 42]

Subd. 9. MS 2025 Supp [Repealed, 2026 c 95 art 4 s 42]

Subd. 10. MS 2025 Supp [Repealed, 2026 c 95 art 4 s 42]

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 sections 142A.60 to 142A.612 or 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, and for a child who is not eligible for Title IV-E of the Social Security Act but who is placed in foster care as determined by Minnesota Statutes or receiving kinship assistance under sections 142A.60 to 142A.612.

Subd. 3. MS 2012 [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. MS 2012 [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 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 12 months postpartum.

Subd. 7. **Aged or blind persons or persons with disabilities.** (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 children with disabilities.** 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. MS 1989 Supp [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. MS 2002 [Repealed, 1Sp2003 c 14 art 12 s 101]

Subd. 10b. MS 2012 [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. **Children with disabilities.** (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 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, or 144.55, subdivision 3, 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 mental illness 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 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 (1) the parent or guardian, (2) the child's physician or physicians, advanced practice registered nurse or advanced practice registered nurses, or physician assistant or physician assistants, and (3) 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.

(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.

[See Note.]

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, 19, or 20.** (a) 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, 19, or 20 years of age or receiving foster care benefits past 18 years of age under section 260C.451, 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.

(b) Medical assistance may be paid for a person under 26 years of age who was in foster care and enrolled in any state's Medicaid program as provided by Public Law 115-271, section 1002.

(c) The commissioner must seek federal waiver approval under United States Code, title 42, section 1315, to include youth who were in a state's foster care program and who turned age 18 prior to January 1, 2023, without regard to potential eligibility under a Medicaid mandatory group.

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; 1Sp2019 c 9 art 7 s 18; 2020 c 115 art 4 s 112; 1Sp2021 c 7 art 1 s 4; 2022 c 58 s 134; 2022 c 98 art 2 s 4; 2023 c 70 art 1 s 9; 2024 c 80 art 1 s 96; 2024 c 115 art 16 s 34; 2025 c 38 art 8 s 57; 2026 c 88 art 1 s 120; 2026 c 127 art 9 s 14*

NOTE: Subdivision 14 is repealed by Laws 2026, chapter 121, article 6, section 36, effective January 1, 2028, or upon federal approval, whichever is later. Laws 2026, chapter 121, article 6, section 36, the effective date.

256B.056 ELIGIBILITY REQUIREMENTS FOR MEDICAL ASSISTANCE.

Subdivision 1. **Residency.** (a) 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. A child who is placed in a family foster home in Minnesota by another state is a Minnesota resident in accordance with Minnesota's interstate agreements and Code of Federal

Regulations, title 42, section 435.403(k). For the purposes of this paragraph, "family foster home" has the meaning given in section 260C.007, subdivision 16b.

(b) The commissioner shall identify individuals who are enrolled in medical assistance and who are absent from the state for more than 30 consecutive days, but who continue to qualify for medical assistance in accordance with paragraph (a).

(c) If the individual is absent from the state for more than 30 consecutive days but still deemed a resident of Minnesota in accordance with paragraph (a), any covered service provided to the individual must be paid through the fee-for-service system and not through the managed care capitated rate payment system under section 256B.69 or 256L.12.

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 in clause (2) and subdivision 3, paragraph (a), clause (6).

(2) State tax credits, rebates, and refunds must not be counted as income. State tax credits, rebates, and refunds must not be counted as assets for a period of 12 months after the month of receipt.

(3) 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 United States Code, title 42, section 1396a(e)(14), 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 1; 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):

(i) the commissioner shall subtract from the individual's modified adjusted gross income an amount equivalent to five percent of the federal poverty guidelines; and

(ii) the individual's current monthly income and household size is used to determine eligibility for the 12-month eligibility period. If an individual's income is expected to vary month to month, eligibility is determined based on the income predicted for the 12-month eligibility period.

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.

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, advanced practice registered nurse, or physician assistant 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) Effective January 1, 2028, the amount specified in paragraph (a) must not exceed $1,000,000.

(c) 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.

(d) 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 members, spouses, 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;

(6) a designated employment incentives asset account is disregarded when determining eligibility for medical assistance for a person age 65 years or older under section 256B.055, subdivision 7. An employment incentives asset account must only be designated by a person who has been enrolled in medical assistance under section 256B.057, subdivision 9, for a 24-consecutive-month period. A designated employment

incentives asset account contains qualified assets owned by the person in the last month of enrollment in medical assistance under section 256B.057, subdivision 9. Qualified assets include retirement and pension accounts, medical expense accounts, and up to $17,000 of the person's other nonexcluded liquid assets. An employment incentives asset account is no longer designated when a person loses medical assistance eligibility for a calendar month or more before turning age 65. A person who loses medical assistance eligibility before age 65 can establish a new designated employment incentives asset account by establishing a new 24-consecutive-month period of enrollment under section 256B.057, subdivision 9. 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 sections 256B.055, subdivision 15, and 256B.057, subdivision 9.

[See Note.]

Subd. 3a. MS 1990 [Repealed, 1992 c 513 art 7 s 135]

Subd. 3b. **Treatment of trusts.** (a) It is the public policy of this state that individuals use all available resources to pay for the cost of long-term care services, as defined in section 256B.0595, before turning to Minnesota health care program funds, and that trust instruments should not be permitted to shield available resources of an individual or an individual's spouse from such use.

(b) A "medical assistance qualifying trust" is a revocable or irrevocable trust, or similar legal device, established on or before August 10, 1993, by a person or the person's spouse under the terms of which the person receives or could receive payments from the trust principal or income and the trustee has discretion in making payments to the person from the trust principal or income. Notwithstanding that definition, a medical assistance qualifying trust does not include: (1) a trust set up by will; (2) a trust set up before April 7, 1986, solely to benefit a person with 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.

(c) Trusts established after August 10, 1993, are treated according to United States Code, title 42, section 1396p(d).

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

(e) 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.

(f) Trusts may be established on or after December 12, 2016, by a person who has been determined to be disabled, according to United States Code, title 42, section 1396p(d)(4)(A), as amended by section 5007 of the 21st Century Cures Act, Public Law 114-255.

[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;

(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;

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

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

(8) 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) Paragraph (a) applies only to parents and caretaker relatives who qualify for medical assistance under subdivision 5.

(c) Eligibility for children under age 21 must be determined without regard to the asset limitations described in paragraphs (a) and (b) and subdivision 3.

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 either one or two calendar months before the month of application in which the applicant seeks coverage, according to the applicant's retroactive eligibility under section 256B.061 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 January 1, 2000, and each successive January, recipients of Supplemental Security Income may have an income up to the Supplemental Security Income standard in effect on that date.

(b) To be eligible for medical assistance 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.

(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 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. MS 2012 [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:

(1) 81 percent of the federal poverty guidelines; and

(2) effective July 1, 2022, the standard specified in subdivision 4, paragraph (a).

Subd. 5d. **Medical assistance room and board rate.** "Medical assistance room and board rate" means an amount equal to 81 percent of the federal poverty guideline for a single individual living alone in the community less the medical assistance personal needs allowance under section 256B.35. The amount of the room and board rate, as defined in section 256I.03, subdivision 14a, that exceeds the medical assistance room and board rate is considered a remedial care cost. A remedial care cost may be used to meet a spenddown obligation under this section. The medical assistance room and board rate is to be adjusted on January 1 of each year.

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 and 256L.12 and Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 4, paragraph (c); 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.** (a) Except as provided in paragraphs (b), (c), and (e), medical assistance enrollees are eligible for 12 months. Until December 31, 2027, eligibility is available for the month of application and for three months prior to application if the person was eligible in those prior months. Effective January 1, 2028, eligibility is available for the month of application and for:

(1) one month prior to application for an individual described in paragraph (e) if the individual was eligible for medical assistance in the prior month; or

(2) two months prior to application for all other individuals eligible for medical assistance if the individual was eligible in those prior months.

(b) A child under six years of age who is determined eligible for medical assistance must remain eligible through the month in which the child reaches six years of age.

(c) A child's eligibility under paragraph (b) may be terminated earlier if:

(1) the child or the child's representative requests voluntary termination of eligibility;

(2) the child ceases to be a resident of this state;

(3) the child dies;

(4) the child attains the maximum age; or

(5) the agency determines eligibility was erroneously granted at the most recent eligibility determination due to agency error or fraud, abuse, or perjury attributed to the child or the child's representative.

(d) For an individual eligible for an insurance affordability program as defined in section 256B.02, subdivision 19, who reports a change that makes the individual eligible for medical assistance, eligibility is available for the month the change was reported and:

(1) until December 31, 2027, for three months prior to the month the change was reported; and

(2) effective January 1, 2028, for:

(i) one month prior to the month the change was reported for an individual described in paragraph (e); or

(ii) two months prior to the month the change was reported for all other individuals eligible for medical assistance if the individual was eligible in the prior month or months.

(e) The period of eligibility for a person subject to six-month eligibility redeterminations under Public Law 119-21, section 71107, is six months.

[See Note.]

Subd. 7a. **Periodic renewal of eligibility.** (a) Except as provided in paragraphs (d) and (e), 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 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. The local agency may close the enrollee's case file if the required information is not submitted within four months of termination.

(d) A person who is eligible under subdivision 5 is subject to a review of the person's income every six months.

(e) A person subject to six-month eligibility redeterminations under Public Law 119-21, section 71107, is subject to a redetermination of 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 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 12-month 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 (c), 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.

(e) Each person applying for or receiving medical assistance under section 256B.055, subdivision 7, and any other person whose resources are required by law to be disclosed to determine the applicant's or recipient's eligibility must authorize the commissioner to obtain information from financial institutions to verify assets as required in section 256.01, subdivision 18f. If a person refuses or revokes the authorization, the commissioner may determine that the applicant or recipient is ineligible for medical assistance. For purposes of this paragraph, an authorization to verify assets meets the requirements of the Right to Financial Privacy Act, United States Code, title 12, chapter 35, and need not be furnished to the financial institution.

(f) County and Tribal agencies shall comply with the standards established by the commissioner for appropriate use of the asset verification system specified in section 256.01, subdivision 18f.

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 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 (a).

(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; 2015 c 71 art 7 s 27; 2016 c 158 art 2 s 84; 2017 c 59 s 8; 1Sp2017 c 6 art 4 s 18-20; 1Sp2019 c 9 art 7 s 19-22; 2020 c 115 art 3 s 16-20; 1Sp2020 c 2 art 2 s 11; 1Sp2021 c 7 art 1 s 5; 2022 c 98 art 2 s 5-7; 2023 c 61 art 3 s 3; 2023 c 70 art 16 s 11; art 17 s 41,62; 2024 c 85 s 62; 2024 c 101 art 3 s 2; 2024 c 127 art 55 s 5,6; 2026 c 127 art 5 s 7; art 6 s 6-9

NOTE: The amendments to subdivision 3, paragraphs (a), clause (5), and (b), by Laws 2023, chapter 61, article 3, section 3, are effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2023, chapter 70, article 15, section 12, as amended by Laws 2024, chapter 85, section 114.

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. 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 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.

NOTE: The amendment to subdivision 3d by Laws 2026, chapter 127, article 6, section 7, is effective January 1, 2028. Laws 2026, chapter 127, article 6, section 7, the effective date.

NOTE: The amendment to subdivision 7 by Laws 2023, chapter 70, article 16, section 11, is effective upon federal approval, except that paragraph (b), clause (1), is effective upon federal approval and the implementation of required administrative and systems changes. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained and the required administrative and systems changes are implemented. Laws 2023, chapter 70, article 16, section 11, the effective date.

256B.0561 PERIODIC DATA MATCHING TO EVALUATE CONTINUED ELIGIBILITY.

Subdivision 1. **Definition.** For the purposes of this section, "periodic data matching" means obtaining updated electronic information about medical assistance and MinnesotaCare recipients on the MNsure information system from federal and state data sources accessible to the MNsure information system and using that data to evaluate continued eligibility between regularly scheduled renewals.

Subd. 2. **Periodic data matching.** (a) The commissioner shall conduct periodic data matching to identify recipients who, based on available electronic data, may not meet eligibility criteria for the public health care program in which the recipient is enrolled. The commissioner shall conduct data matching for medical assistance or MinnesotaCare recipients at least once during a recipient's 12-month period of eligibility, except as provided in paragraph (f).

(b) If data matching indicates a recipient may no longer qualify for medical assistance or MinnesotaCare, the commissioner must notify the recipient and allow the recipient no more than 30 days to confirm the information obtained through the periodic data matching or provide a reasonable explanation for the discrepancy to the state or county agency directly responsible for the recipient's case. If a recipient does not respond within the advance notice period or does not respond with information that demonstrates eligibility or provides a reasonable explanation for the discrepancy within the 30-day time period, the commissioner

shall terminate the recipient's eligibility in the manner provided for by the laws and regulations governing the health care program for which the recipient has been identified as being ineligible.

(c) The commissioner shall not terminate eligibility for a recipient who is cooperating with the requirements of paragraph (b) and needs additional time to provide information in response to the notification.

(d) A recipient whose eligibility was terminated according to paragraph (b) may be eligible for medical assistance no earlier than the first day of the month in which the recipient provides information that demonstrates the recipient's eligibility.

(e) Any termination of eligibility for benefits under this section may be appealed as provided for in sections 256.045 to 256.0451, and the laws governing the health care programs for which eligibility is terminated.

(f) Effective January 1, 2027, a person subject to six-month eligibility redeterminations under Public Law 119-21, section 71107, is exempt from periodic data matching under this subdivision.

Subd. 3. **Recipient communication requirements.** The commissioner shall include in all communications with recipients affected by the periodic data matching the following contact information for: (1) the state or county agency directly responsible for the recipient's case; and (2) consumer assistance partners who may be able to assist the recipient in the periodic data matching process.

Subd. 4. MS 2024 [Expired, 2022 c 98 art 14 s 20]

Subd. 5. **Federal compliance.** The commissioner shall ensure that the implementation of this section complies with the Affordable Care Act, including the state's maintenance of effort requirements. The commissioner shall not terminate eligibility under this section if eligibility terminations would not conform with federal requirements, including requirements not yet codified in Minnesota Statutes.

History: *2015 c 71 art 11 s 17; 1Sp2017 c 6 art 4 s 21,22; 2020 c 115 art 3 s 21; 2022 c 98 art 14 s 20; 2026 c 127 art 6 s 10*

256B.0562 WORK OR COMMUNITY ENGAGEMENT REQUIREMENTS.

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

(b) "Applicable individual" has the meaning given in Public Law 119-21, section 71119, paragraph (9).

(c) "Short-term hardship event" means an event in which a person:

(1) receives inpatient hospital or nursing facility services, services in an intermediate care facility for individuals with intellectual disabilities, inpatient psychiatric hospital services, or other services of similar acuity;

(2) resides in a county in which there is an emergency or disaster declared by the President of the United States pursuant to the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act;

(3) resides in a county that has an unemployment rate at or above the lesser of:

(i) eight percent; or

(ii) 1.5 times the national unemployment rate; or

(4) must travel, or the person's dependent must travel, outside of the person's community for an extended period of time to receive medical services that are not available within the community of residence necessary to treat a serious or complex medical condition of the person or the person's dependent.

Subd. 2. **Application.** To be eligible for medical assistance, an applicable individual applying for medical assistance must either demonstrate work or community engagement or meet an exemption in accordance with Public Law 119-21, section 71119, for the month immediately preceding the month during which the person submits an application for medical assistance.

Subd. 3. **Renewal requirement.** (a) To renew eligibility, an applicable individual must either demonstrate work or community engagement or meet an exemption in accordance with Public Law 119-21, section 71119, for at least one month during the person's previous period of eligibility.

(b) The commissioner must notify an applicable individual of the renewal requirement in paragraph (a) at least 75 days prior to the individual's renewal date.

Subd. 4. **Short-term hardship events.** A person is deemed to have met the requirement to demonstrate work or community engagement for a given month under subdivisions 2 and 3 if (1) the person experiences a short-term hardship event for part or all of that month, and (2) for purposes of a short-term hardship described in subdivision 1, paragraph (c), clause (1) or (4), the person submits a request to the commissioner.

Subd. 5. **Noncompliance procedure.** Before denying or terminating medical assistance eligibility for failure to demonstrate work or community engagement or meet an exemption, the commissioner must comply with the procedures in the case of noncompliance set forth in Public Law 119-21, section 71119, paragraph (6).

Subd. 6. **Interpretation of federal law.** (a) In all cases where an obligation imposed on the commissioner under Public Law 119-21, section 71119, is materially ambiguous, the commissioner must construe the ambiguity in the light most favorable to the applicant, enrollee, or disenrollee, as applicable. For purposes of this subdivision, an obligation on the commissioner includes but is not limited to an obligation respecting the following:

(1) enrollee notice and outreach;

(2) demonstration of work or community engagement;

(3) medical frailty;

(4) fair hearing rights;

(5) the provision of medical assistance benefits or coverage;

(6) submission documentation, including self-attestations of eligibility or exemption;

(7) eligibility or termination determinations;

(8) short-term hardship requests; and

(9) timing.

(b) Paragraph (a) does not require the commissioner to take any action that the commissioner determines:

(1) is more likely than not to result in a loss of federal financial participation;

(2) would be clearly impractical, absurd, or unreasonably detrimental to the medical assistance program or another insurance affordability program; or

(3) relies on an unreasonable interpretation of federal law.

(c) Prior to the interpretation of an ambiguity under paragraph (a), the commissioner must, in order to determine the reasonable interpretation of the applicable federal law most favorable to an applicant, enrollee, or disenrollee:

(1) consult with the health care eligibility oversight unit established in section 256.01;

(2) consult with the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance and policy; and

(3) take best efforts to consult with, and receive guidance from, the Centers for Medicare and Medicaid Services.

Subd. 7. **Expedited rulemaking authority.** The commissioner may adopt rules necessary to implement and administer this section using the expedited rulemaking process under section 14.389. The 18-month time limit under section 14.125 does not apply to the rulemaking authority under this subdivision.

History: *2026 c 127 art 6 s 11*

256B.0563 REVIEW OF DEATH MASTER FILE.

Subdivision 1. **Definition.** For purposes of this section, "death master file" means information about deceased individuals maintained by the Social Security Administration under United States Code, title 42, section 1306c(d), or any successor system.

Subd. 2. **Review of the death master file.** (a) Beginning January 1, 2027, the commissioner must review the death master file at least quarterly to identify any medical assistance recipients who are deceased.

(b) If review of the death master file or any other source indicates that a recipient is deceased, the commissioner must:

(1) terminate the recipient's eligibility for medical assistance in the manner provided for by the laws and regulations governing medical assistance;

(2) notify the recipient and the recipient's representative no later than the date of the termination; and

(3) discontinue any payments to providers under this chapter made on behalf of the recipient as of the date of the termination.

(c) If the commissioner determines that a recipient was misidentified as deceased and erroneously disenrolled from medical assistance based on information obtained from the death master file or any other source, the commissioner must immediately re-enroll the individual in medical assistance retroactive to the date of termination under paragraph (b).

Subd. 3. **Review of other sources.** Nothing in this section prevents the commissioner from reviewing other sources to identify recipients of medical assistance who are deceased, provided the commissioner is in compliance with this section and all other requirements under this chapter related to medical assistance eligibility determination and redetermination.

History: *2026 c 127 art 6 s 12*

256B.057 ELIGIBILITY REQUIREMENTS FOR SPECIAL CATEGORIES.

Subdivision 1. **Infants and pregnant women.** (a) An infant less than two years of age is eligible for medical assistance if the infant's countable household income is equal to or less than 283 percent of the federal poverty guideline for the same household size. Medical assistance for an uninsured infant younger than two years of age may be paid with federal funds available under title XXI of the Social Security Act and the state children's health insurance program, for an infant with countable income above 275 percent and equal to or less than 283 percent of the federal poverty guideline for the household size.

(b) A pregnant woman is eligible for medical assistance if the woman's countable income is equal to or less than 278 percent of the federal poverty guideline for the applicable household size.

(c) 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. MS 1997 Supp [Repealed, 1998 c 407 art 5 s 48]

Subd. 1b. MS 2002 [Repealed, 1Sp2003 c 14 art 12 s 101]

Subd. 1c. MS 2012 [Repealed, 2013 c 108 art 1 s 68]

Subd. 2. MS 2012 [Repealed, 2013 c 108 art 1 s 68]

Subd. 2a. MS 1996 [Repealed, 1997 c 203 art 4 s 73]

Subd. 2b. MS 1996 [Repealed, 1997 c 203 art 4 s 73]

Subd. 2c. MS 2010 [Repealed, 1Sp2011 c 9 art 6 s 97]

Subd. 3. **Qualified Medicare beneficiaries.** (a) A person is eligible for medical assistance reimbursement of Medicare 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 if:

(1) the person is entitled to Medicare Part A benefits;

(2) the person's income is equal to or less than 100 percent of the federal poverty guidelines; and

(3) the person's assets are no more than (i) $10,000 for a single individual, or (ii) $18,000 for a married couple or family of two or more; or, when the resource limits for eligibility for the Medicare Part D extra help low income subsidy (LIS) exceed either amount in item (i) or (ii), the person's assets are no more than the LIS resource limit in United States Code, title 42, section 1396d, subsection (p).

(b) 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 adults with disabilities.** A person who is entitled to Medicare Part A benefits under section 1818A of the Social Security Act; whose income does not exceed 200 percent of the federal poverty guidelines for the applicable family size; whose nonexempt assets do not exceed twice the maximum amount allowable under the Supplemental Security Income program, according to family size; and who is not otherwise eligible for medical assistance, is eligible for medical assistance reimbursement of the Medicare Part A premium.

Subd. 5. **Adult children with a disability.** 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. MS 2020 [Repealed, 2022 c 98 art 2 s 16]

Subd. 8. MS 2018 [Repealed, 2020 c 115 art 3 s 40]

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; and

(2) pays a premium and other obligations under paragraph (d).

(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, be receiving an unemployment insurance benefit under chapter 268 that the person began receiving while eligible under this subdivision, or be receiving family and medical leave benefits under chapter 268B that the person began receiving while eligible under this subdivision. A person who is self-employed must file and pay all applicable taxes. Any spousal income 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 would otherwise be ineligible and be disenrolled due to one of the following circumstances may retain eligibility for up to four consecutive months after a month of job loss if the person:

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

(2) loses employment for reasons not attributable to the enrollee, and is without receipt of earned income.

To receive a four-month extension of continued eligibility under this paragraph, enrollees must verify the medical condition or provide notification of job loss, continue to meet all other eligibility requirements, and continue to pay all calculated premium costs.

(d) 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 $35 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 one-half of one 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.

(e) 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.

(f) Any required premium shall be determined at application and redetermined at the enrollee's 12-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 30 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 12-month review.

(g) 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.

(h) Nonpayment of the premium shall result in denial or termination of medical assistance unless the person demonstrates good cause for nonpayment. "Good cause" means an excuse for the enrollee's failure to pay the required premium when due because the circumstances were beyond the enrollee's control or not

reasonably foreseeable. The commissioner shall determine whether good cause exists based on the weight of the supporting evidence submitted by the enrollee to demonstrate good cause. The commissioner must not determine that good cause exists for a month for which the premium has already been paid. 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.

(i) 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).

(j) The commissioner is authorized to determine that a premium amount was calculated or billed in error, make corrections to financial records and billing systems, and refund premiums collected in error.

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 any Centers for Disease Control and Prevention (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP)-funded 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 any CDC NBCCEDP-funded 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; 1997 c 85 art 3 s 16-18; 1997 c 203 art 4 s 22-24; 1998 c 407 art 4 s 17,18; art 5 s 3-5; 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; 2015 c 71 art 7 s 28; 2017 c 59 s 9; 1Sp2017 c 6 art 4 s 23; 2020 c 115 art 3 s 22,23; 2021 c 30 art 1 s 7; 2023 c 59 art 2 s 1; 2023 c 61 art 3 s 4; 2024 c 108 art 1 s 11; 2026 c 95 art 9 s 6*

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. MS 2005 Supp [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. MS 2005 Supp [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. MS 2006 [Repealed, 2008 c 326 art 1 s 47]

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.

(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. MS 2008 [Repealed, 2010 c 310 art 4 s 5]

Subd. 11. MS 2005 Supp [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 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, whichever amount is greater;

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

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

(4) a monthly income allowance determined under section 256B.058, subdivision 2, but only to the extent income of the institutionalized spouse is made available to the community spouse;

(5) a monthly allowance for children under age 18 which, together with the net income of the children, would provide income equal to the medical assistance standard for families and children according to section 256B.056, subdivision 4, for a family size that includes only the minor children. This deduction applies only if the children do not live with the community spouse and only to the extent that the deduction is not included in the personal needs allowance under section 256B.35, subdivision 1, as child support garnished under a court order;

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

(7) reparations payments made by the Federal Republic of Germany and reparations payments made by the Netherlands for victims of Nazi persecution between 1940 and 1945;

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

(9) amounts for reasonable expenses, 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, advanced practice registered nurse, or physician assistant 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;

(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;

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

(5) for private room fees incurred by an assisted living resident, as defined in section 144G.08, subdivision 59.

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; 2018 c 170 s 7; 2020 c 115 art 3 s 24,25; 2022 c 58 s 135; 2023 c 25 s 137*

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 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 of the federal Food and Nutrition Act of 2008. 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 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):

(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; 2024 c 85 s 63*

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) "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).

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

(e) "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 chapter 256S, 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 chapter 256S or section 256B.092 or 256B.49.

(f) "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.

(g) "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;

(3) the services are paid by the EW program under chapter 256S 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. MS 2014 [Repealed, 2016 c 189 art 19 s 31]

Subd. 2. **Assessment of marital assets.** Upon application for medical assistance benefits for an institutionalized spouse, the total value of assets in which either the institutionalized spouse or the community spouse has an interest shall be assessed and the community spouse asset allowance shall be calculated as required in subdivision 3.

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 the greater of:

(1) $119,220 subject to an annual adjustment on January 1, 2017, and every January 1 thereafter, equal to the percentage increase in the Consumer Price Index for All Urban Consumers (all items; United States city average) between the two previous Septembers; or

(2) 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.

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

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

Subd. 5. **Asset availability.** (a) At the time of initial determination of eligibility for medical assistance benefits for an institutionalized spouse, 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 amount available to the community spouse under subdivision 3.

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. 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.

(c) After the month in which the institutionalized spouse is determined eligible for medical assistance, and during the continuous period of enrollment, 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.

Subd. 6. **Temporary application.** (a) During the period in which rules against spousal impoverishment are temporarily applied according to section 2404 of the Patient Protection Affordable Care Act, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, this section applies to an institutionalized spouse:

(1) applying for home and community-based waivers under sections 256B.092, 256B.093, and 256B.49 on or after June 1, 2016;

(2) enrolled in home and community-based waivers under sections 256B.092, 256B.093, and 256B.49 before June 1, 2016, based on an application submitted on or after January 1, 2014; or

(3) applying for services under section 256B.85 upon the effective date of that section.

(b) During the applicable period of paragraph (a), the definition of "institutionalized spouse" in subdivision 1, paragraph (e), also includes an institutionalized spouse referenced in paragraph (a).

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; 2015 c 71 art 7 s 29; 2016 c 189 art 19 s 4-8; 2017 c 40 art 1 s 65,66; 1Sp2017 c 6 art 4 s 24; 2019 c 54 art 2 s 17*

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) For purposes of this section, "long-term care services" includes 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; services in an intermediate care facility for persons with developmental disabilities; and home and community-based services provided pursuant to sections 256B.092 and 256B.49 and chapter 256S. For purposes of this subdivision and subdivisions 2, 3, and 4, "institutionalized person" includes a person who is an inpatient in a nursing facility, a swing bed, or an intermediate care facility for persons with developmental disabilities, or who is receiving home and community-based services under sections 256B.092 and 256B.49 and chapter 256S.

(b) 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 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.

(c) This section applies to transfers, for less than fair market value, of income or assets, including assets that are considered income in the month received, such as inheritances, court settlements, and retroactive benefit payments or income to which the 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.

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

(e) 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 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:

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

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

(iii) 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) 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.

(h) In the case of a promissory note, loan, or mortgage that does not meet an exception in paragraph (g), 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:

(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.

Subd. 1a. MS 2000 [Repealed, 2001 c 203 s 19]

Subd. 1b. MS 2008 [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 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.

Subd. 2a. MS 2000 [Repealed, 2001 c 203 s 19]

Subd. 2b. MS 2008 [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, advanced practice registered nurse, or physician assistant, 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-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.

Subd. 3a. MS 2000 [Repealed, 2001 c 203 s 19]

Subd. 3b. MS 2008 [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 (a), 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 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.

Subd. 4a. MS 2000 [Repealed, 2001 c 203 s 19]

Subd. 4b. MS 2008 [Repealed, 2010 c 310 art 5 s 1]

Subd. 5. MS 2008 [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);

(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; 2018 c 170 s 8; 2019 c 54 art 2 s 18; 2022 c 58 s 136; 2022 c 98 art 2 s 8; 2024 c 85 s 64,65*

256B.0596 MS 2020 [Repealed, 1Sp2021 c 7 art 6 s 29, art 11 s 49]

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]

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. MS 1973 Supp [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) Except as provided in paragraph (c), eligibility for medical assistance is limited to citizens and nationals of the United States and noncitizens who are eligible for coverage with federal financial participation provided by Medicaid or the Children's Health Insurance Program. Noncitizens who are eligible for federal financial participation include but are not limited to:

(1) children and pregnant women who are lawfully residing in the United States as provided by section 214 of the federal Children's Health Insurance Program Reauthorization Act of 2009, Public Law 111-3, and who otherwise meet eligibility requirements of this chapter; and

(2) pregnant noncitizens who are ineligible for federal financial participation because of immigration status; who 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. These individuals are eligible for medical assistance through the period of pregnancy, including labor and delivery, and 12 months postpartum.

(b) 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.

(c) Beginning October 1, 2003, persons who are receiving care and rehabilitation services from a nonprofit center established to serve victims of torture and who 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 are not required to participate in prepaid medical assistance. The nonprofit center referenced in 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.

(d) Nonimmigrants who otherwise meet the eligibility requirements of this chapter are eligible for the benefits as provided in paragraphs (e) to (g). 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).

(e) 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.

(f) 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).

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

(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) substance use disorder treatment.

(h) Notwithstanding paragraph (g), clause (2), the following services are covered as emergency medical conditions under paragraph (e) except where coverage is prohibited under federal law for services under clauses (1) and (2):

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

(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; and

(3) kidney transplant if the person has been diagnosed with end stage renal disease, is currently receiving dialysis services, and is a potential candidate for a kidney transplant.

(i) Effective July 1, 2013, recipients of emergency medical assistance under this subdivision are eligible for coverage of the elderly waiver services provided under chapter 256S, 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).

Subd. 6. [Renumbered 142A.40]

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; 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; 2015 c 71 art 11 s 18; 2016 c 189 art 19 s 9; 2019 c 54 art 2 s 19; 1Sp2021 c 7 art 1 s 6; 2022 c 98 art 4 s 51; 2024 c 80 art 1 s 96; 2024 c 115 art 16 s 34; 2026 c 127 art 6 s 13*

256B.061 ELIGIBILITY; RETROACTIVE EFFECT; RESTRICTIONS.

(a) If any individual has been determined to be eligible for medical assistance and is subject to six-month eligibility redeterminations under Public Law 119-21, section 71107, medical assistance will be made available for care and services included under the plan and furnished in or after the first 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.

(b) If any individual has been determined to be eligible for medical assistance and is not subject to six-month eligibility redeterminations under Public Law 119-21, section 71107, medical assistance will be made available for care and services included under the plan and furnished in or after the second 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.

(c) 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; 2026 c 127 art 6 s 14*

NOTE: The amendment to this section by Laws 2026, chapter 127, article 6, section 14, is effective January 1, 2028. Laws 2026, chapter 127, article 6, section 14, the effective date.

256B.0615 MENTAL HEALTH CERTIFIED PEER SPECIALIST.

Subdivision 1. **Scope.** Medical assistance covers mental health certified peer specialist services if provided to recipients who are eligible for services under sections 256B.0622, 256B.0623, 256B.0624, and 256B.0632 and are provided by a mental health certified peer specialist who has completed the training under subdivision 5 and is qualified according to section 245I.04, subdivision 10.

Subd. 2. MS 2020 [Repealed, 2021 c 30 art 17 s 113]

Subd. 3. **Eligibility.** Peer support services may be made available to consumers of (1) intensive residential treatment services under section 256B.0632; (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 certification.** A certified peer specialist is qualified as a mental health certified peer specialist, as defined in section 245I.04.

History: *2007 c 147 art 8 s 16; 2009 c 167 s 7,8; 2014 c 312 art 29 s 6; 2015 c 71 art 2 s 22; 2016 c 163 art 2 s 3,4; 2017 c 79 s 4; 2021 c 30 art 17 s 50,51; 2023 c 50 art 3 s 8,9; 2025 c 38 art 7 s 7,8; 2026 c 88 art 1 s 121*

256B.0616 MENTAL HEALTH CERTIFIED FAMILY PEER SPECIALIST.

Subdivision 1. **Scope.** Medical assistance covers mental health certified family peer specialists services, subject to federal approval, if provided to recipients who have a mental illness or serious mental illness under chapter 245, and are provided by a mental health certified family peer specialist who has completed the training under subdivision 5 and is qualified according to section 245I.04, subdivision 12. A family peer specialist cannot provide services to the peer specialist's family.

Subd. 2. MS 2020 [Repealed, 2021 c 30 art 17 s 113]

Subd. 3. **Eligibility.** Family peer support services may be provided to recipients of inpatient hospitalization, partial hospitalization, residential treatment, children's intensive behavioral health services, day treatment, children's therapeutic services and supports, or crisis services.

Subd. 4. **Family peer support program providers.** The commissioner shall develop a process to certify family peer support 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.** (a) The commissioner shall develop or approve the use of an existing training and certification process for certifying family peer specialists. Family peer specialist candidates must have raised or be currently raising a child with a mental illness; have experience navigating the children's mental health system; and demonstrate leadership and advocacy skills and a strong dedication to family-driven and family-focused services. The training curriculum must teach participating family peer specialist candidates specific skills relevant to providing peer support to other parents and youth.

(b) In addition to initial training and certification, the commissioner shall develop ongoing continuing educational workshops on pertinent issues related to family peer support counseling.

(c) Initial training leading to certification as a family peer specialist and continuing education for certified family peer specialists must be delivered by the commissioner or a third-party organization approved by the commissioner. An approved third-party organization may also provide continuing education of certified family peer specialists.

History: *2013 c 108 art 4 s 15; 2017 c 79 s 5; 2021 c 30 art 17 s 52-54; 2022 c 99 art 1 s 48; 2025 c 38 art 4 s 35,36; art 8 s 58; 2026 c 88 art 1 s 122*

256B.0617 MENTAL HEALTH SERVICES PROVIDER CERTIFICATION.

(a) The commissioner of human services shall establish an initial provider entity application and certification and recertification processes to determine whether a provider entity has administrative and clinical infrastructures that meet the certification requirements. This process applies to providers of the following services:

(1) children's intensive behavioral health services under section 256B.0946; and

(2) intensive nonresidential rehabilitative mental health services under section 256B.0947.

(b) The commissioner shall recertify a provider entity every three years using the individual provider's certification anniversary or the calendar year end. The commissioner may approve a recertification extension in the interest of sustaining services when a certain date for recertification is identified.

(c) The commissioner shall establish a process for decertification of a provider entity and shall require corrective action, medical assistance repayment, or decertification of a provider entity that no longer meets the requirements in this section or that fails to meet the clinical quality standards or administrative standards provided by the commissioner in the application and certification process.

(d) The commissioner must provide the following to provider entities for the certification, recertification, and decertification processes:

(1) a structured listing of required provider certification criteria;

(2) a formal written letter with a determination of certification, recertification, or decertification signed by the commissioner or the appropriate division director; and

(3) a formal written communication outlining the process for necessary corrective action and follow-up by the commissioner signed by the commissioner or their designee, if applicable. In the case of corrective action, the commissioner may schedule interim recertification site reviews to confirm certification or decertification.

History: *2024 c 127 art 61 s 14*

256B.0618 COVERAGE FOR DETAINED INDIVIDUALS.

(a) An inmate of a correctional facility who is conditionally released under section 241.26, 244.065, or 631.425 is eligible for medical assistance if the individual:

(1) does not require the security of a public detention facility and is housed:

(i) in a halfway house or community correction center; or

(ii) under house arrest and monitored by electronic surveillance in a residence approved by the commissioner of corrections; and

(2) meets all other eligibility requirements of this chapter.

(b) 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 medical assistance services received:

(1) while an inpatient in a medical institution as defined in Code of Federal Regulations, title 42, section 435.1010;

(2) by an eligible juvenile in accordance with the Consolidated Appropriations Act, 2023, Public Law 117-328, part 5121; or

(3) by an eligible individual under section 256B.0761.

(c) Security logistics and costs related to the inpatient treatment of an inmate are the responsibility of the entity with jurisdiction over the inmate.

History: *2026 c 121 art 6 s 13*

NOTE: This section, as added by Laws 2026, chapter 121, article 6, section 13, is effective January 1, 2028. Laws 2026, chapter 121, article 6, section 13, the effective date.

256B.0619 CARCERAL TARGETED CASE MANAGEMENT SERVICES.

Subdivision 1. **Generally.** Effective January 1, 2028, or upon federal approval, whichever is later, medical assistance covers carceral targeted case management services in accordance with section 256B.0761 and United States Code, title 42, sections 1396a(a)(84); 1396d(a)(32); 1397bb(d); and 1397jj(b)(2) and (7).

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

(b) "Comprehensive care plan" means a person-centered plan that includes goals, tasks, and services identified through screening and assessments and agreed upon by all parties. A comprehensive care plan includes but is not limited to identifying resources and services necessary to meet the individual's physical, behavioral health, and health-related social needs prerelease and postrelease.

(c) "Consultation" means communication from a carceral targeted case manager to other providers working with the same justice-involved individual to (1) inform, inquire, and instruct providers on the individual's symptoms, strategies for effective engagement, care and intervention needs, and treatment expectations across service settings, and (2) direct and coordinate clinical service components provided to the justice-involved individual. Service settings and components include but are not limited to education services, social services, probation, an individual's home, primary care, medication prescribers, disabilities services, and services from other mental health providers.

(d) "Targeted case management for justice-involved individuals" means the provision of both county targeted case management and public or private vendor service coordination services to bridge prerelease and postrelease medical assistance services that support the physical, behavioral, and health-related social needs of justice-involved individuals.

(e) "Targeted case management services" means services that assist medical assistance eligible persons with accessing needed medical, social, educational, and other services.

Subd. 3. **Eligibility.** The following individuals are eligible for carceral targeted case management services:

(1) individuals eligible for medical assistance who meet all eligibility requirements under United States Code, title 42, section 1396a(nn);

(2) individuals eligible for medical assistance who meet eligibility requirements for the Children's Health Insurance Program under United States Code, title 42, section 1397jj(b)(7); or

(3) individuals eligible for medical assistance who are currently incarcerated at a section 1115 reentry demonstration pilot facility and meet the participation requirements in section 256B.0761, subdivision 2.

Subd. 4. **Carceral targeted case management services.** (a) For individuals eligible for services under subdivision 3, clause (1) or (2), carceral targeted case management care coordination is available for 30 days before release and up to 180 days postrelease. For individuals eligible for services under subdivision 3, clause (3), carceral targeted case management care coordination is available for up to 90 days before release and up to 180 days postrelease.

(b) Carceral targeted case management care coordination includes:

(1) comprehensive assessment and periodic reassessment addressing physical, behavioral, and health-related social needs in accordance with section 256B.0761 and United States Code, title 42, sections 1396a(nn) and 1397jj(b)(7);

(2) comprehensive care plans, including but not limited to:

(i) the desired goals of the individual;

(ii) the individual's preferences for services and supports;

(iii) formal and informal services and supports based on areas of assessment, such as social health, mental health, residence, family, education and vocation, safety, legal, self-determination, financial, and chemical health; and

(iv) housing arrangements postrelease;

(3) regular review and revision of the comprehensive care plan with the individual to ensure needs are adequately met by referrals and supports;

(4) coordination of referrals, which must consist of efforts beyond providing a list of resources, to bridge prerelease to postrelease medical assistance services, including but not limited to referrals to community-based services identified as a need on the comprehensive care plan;

(5) warm handoffs and postrelease follow-up through direct coordination between providers, including timely communication, active engagement of the individual when feasible, and facilitation of continuity of care upon release;

(6) monitoring and evaluation of services identified in the comprehensive care plan to ensure personal outcomes are met and to ensure satisfaction with services and service delivery;

(7) consultation with other professionals, including but not limited to community-based mental health providers; and

(8) completion and maintenance of necessary documentation that supports and verifies the activities in this section.

Subd. 5. **Carceral targeted case management provider standards.** Providers eligible to receive medical assistance reimbursement under this section must enroll as a Minnesota health care programs provider. To qualify as a provider of carceral targeted case management services, a provider must:

(1) 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 credentials from an American Indian Tribe under section 256B.02, subdivision 7;

(2) demonstrate the capacity and experience to provide targeted case management activities for justice-involved individuals as defined in subdivision 2;

(3) be able to coordinate and connect community resources needed by the recipient;

(4) demonstrate administrative capacity and experience to serve the justice-involved population for which the provider will provide services and to ensure quality of services under state and federal requirements;

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

(6) demonstrate capacity to document and maintain individual case records under state and federal requirements;

(7) demonstrate the capacity to coordinate with county administrative functions;

(8) be able to coordinate with health care providers to ensure access to necessary health care services;

(9) have a procedure that:

(i) notifies the recipient of any conflict of interest if the targeted case management service provider also provides the recipient's services and supports;

(ii) provides information on all potential conflicts of interest;

(iii) obtains the recipient's informed consent; and

(iv) provides the recipient with alternatives; and

(10) demonstrate the capacity to achieve the following performance outcomes: (i) access; (ii) quality; and (iii) consumer satisfaction.

Subd. 6. **Medical assistance payment and rate setting.** (a) Carceral targeted case management rates are equal to rates authorized by the commissioner for relocation targeted case management under section 256B.0621, subdivision 10.

(b) The carceral targeted case management rate only includes eligible services delivered to an eligible recipient by an eligible provider.

History: *2026 c 121 art 6 s 14*

256B.062 MS 1997 Supp [Repealed, 1998 c 407 art 6 s 12,118]

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

Subdivision 1. MS 2001 Supp [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 246C.12; 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.

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 260E.14; 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;

(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.

(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 contact, telephone contact, and interactive video contact as defined in section 256B.0625, subdivision 20b, paragraph (f), 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;

(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; 1Sp2017 c 6 art 4 s 25; 1Sp2020 c 2 art 8 s 90; 1Sp2021 c 7 art 6 s 9; 2024 c 79 art 10 s 2*

256B.0622 ASSERTIVE COMMUNITY TREATMENT.

Subdivision 1. **Scope.** (a) Subject to federal approval, medical assistance covers medically necessary, assertive community treatment when the services are provided by an entity certified under and meeting the standards in this section.

(b) The provider entity must make reasonable and good faith efforts to report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner.

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

(b) "ACT team" means the group of interdisciplinary mental health staff who work as a team to provide assertive community treatment.

(c) "Assertive community treatment" means intensive nonresidential treatment and rehabilitative mental health services provided according to the assertive community treatment model. Assertive community treatment provides a single, fixed point of responsibility for treatment, rehabilitation, and support needs for clients. Services are offered 24 hours per day, seven days per week, in a community-based setting.

(d) "Individual treatment plan" means a plan described by section 245I.10, subdivisions 7 and 8.

(e) "Crisis assessment and intervention" means mobile crisis response services under section 256B.0624.

(f) "Individual treatment team" means a minimum of three members of the ACT team who are responsible for consistently carrying out most of a client's assertive community treatment services.

(g) "Primary team member" means the person who leads and coordinates the activities of the individual treatment team and is the individual treatment team member who has primary responsibility for establishing and maintaining a therapeutic relationship with the client on a continuing basis.

(h) "Certified rehabilitation specialist" means a staff person who is qualified according to section 245I.04, subdivision 8.

(i) "Clinical trainee" means a staff person who is qualified according to section 245I.04, subdivision 6.

(j) "Mental health certified peer specialist" means a staff person who is qualified according to section 245I.04, subdivision 10.

(k) "Mental health practitioner" means a staff person who is qualified according to section 245I.04, subdivision 4.

(l) "Mental health professional" means a staff person who is qualified according to section 245I.04, subdivision 2.

(m) "Mental health rehabilitation worker" means a staff person who is qualified according to section 245I.04, subdivision 14.

Subd. 2a. **Eligibility for assertive community treatment.** (a) An eligible client for assertive community treatment is an individual who meets the following criteria as assessed by an ACT team:

(1) is age 18 or older. Individuals ages 16 and 17 may be eligible upon approval by the commissioner;

(2) has a primary diagnosis of schizophrenia, schizoaffective disorder, major depressive disorder with psychotic features, other psychotic disorders, or bipolar disorder. Individuals with other psychiatric illnesses may qualify for assertive community treatment if they have a serious mental illness and meet the criteria outlined in clauses (3) and (4), but no more than ten percent of an ACT team's clients may be eligible based on this criteria. Individuals with a primary diagnosis of a substance use disorder, intellectual developmental disabilities, borderline personality disorder, antisocial personality disorder, traumatic brain injury, or an autism spectrum disorder are not eligible for assertive community treatment;

(3) has significant functional impairment as demonstrated by at least one of the following conditions:

(i) significant difficulty consistently performing the range of routine tasks required for basic adult functioning in the community or persistent difficulty performing daily living tasks without significant support or assistance;

(ii) significant difficulty maintaining employment at a self-sustaining level or significant difficulty consistently carrying out the head-of-household responsibilities; or

(iii) significant difficulty maintaining a safe living situation;

(4) has a need for continuous high-intensity services as evidenced by at least two of the following:

(i) two or more psychiatric hospitalizations or residential crisis stabilization services in the previous 12 months;

(ii) frequent utilization of mental health crisis services in the previous six months;

(iii) 30 or more consecutive days of psychiatric hospitalization in the previous 24 months;

(iv) intractable, persistent, or prolonged severe psychiatric symptoms;

(v) coexisting mental health and substance use disorders lasting at least six months;

(vi) recent history of involvement with the criminal justice system or demonstrated risk of future involvement;

(vii) significant difficulty meeting basic survival needs;

(viii) residing in substandard housing, experiencing homelessness, or facing imminent risk of homelessness;

(ix) significant impairment with social and interpersonal functioning such that basic needs are in jeopardy;

(x) coexisting mental health and physical health disorders lasting at least six months;

(xi) residing in an inpatient or supervised community residence but clinically assessed to be able to live in a more independent living situation if intensive services are provided;

(xii) requiring a residential placement if more intensive services are not available; or

(xiii) difficulty effectively using traditional office-based outpatient services;

(5) there are no indications that other available community-based services would be equally or more effective as evidenced by consistent and extensive efforts to treat the individual; 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 assertive community treatment is not provided.

(b) An individual meets the criteria for assertive community treatment under this section if they have participated within the last year or are currently participating in a first episode of psychosis program if the individual:

(1) meets the eligibility requirements outlined in paragraph (a), clauses (1), (2), (5), and (6); and

(2) needs the level of intensity provided by an ACT team, in the opinion of the individual's first episode of psychosis program, in order to prevent crisis services use, hospitalization, homelessness, and involvement with the criminal justice system.

Subd. 2b. **Continuing stay and discharge criteria for assertive community treatment.** (a) A client receiving assertive community treatment is eligible to continue receiving services if:

(1) the client has not achieved the desired outcomes of their individual treatment plan;

(2) the client's level of functioning has not been restored, improved, or sustained over the time frame outlined in the individual treatment plan;

(3) the client continues to be at risk for relapse based on current clinical assessment, history, or the tenuous nature of the functional gains; or

(4) the client is functioning effectively with this service and discharge would otherwise be indicated but without continued services the client's functioning would decline; and

(5) one of the following must also apply:

(i) the client has achieved current individual treatment plan goals but additional goals are indicated as evidenced by documented symptoms;

(ii) the client is making satisfactory progress toward meeting goals and there is documentation that supports that continuation of this service shall be effective in addressing the goals outlined in the individual treatment plan;

(iii) the client is making progress, but the specific interventions in the individual treatment plan need to be modified so that greater gains, which are consistent with the client's potential level of functioning, are possible; or

(iv) the client fails to make progress or demonstrates regression in meeting goals through the interventions outlined in the individual treatment plan.

(b) Clients receiving assertive community treatment are eligible to be discharged if they meet at least one of the following criteria:

(1) the client and the ACT team determine that assertive community treatment services are no longer needed based on the attainment of goals as identified in the individual treatment plan and a less intensive level of care would adequately address current goals;

(2) the client moves out of the ACT team's service area and the ACT team has facilitated the referral to either a new ACT team or other appropriate mental health service and has assisted the individual in the transition process;

(3) the client, or the client's legal guardian when applicable, chooses to withdraw from assertive community treatment services and documented attempts by the ACT team to re-engage the client with the service have not been successful;

(4) the client has a demonstrated need for a medical nursing home placement lasting more than three months, as determined by a physician, advanced practice registered nurse, or physician assistant;

(5) the client is hospitalized, in residential treatment, or in jail for a period of greater than three months. However, the ACT team must make provisions for the client to return to the ACT team upon their discharge or release from the hospital or jail if the client still meets eligibility criteria for assertive community treatment and the team is not at full capacity;

(6) the ACT team is unable to locate, contact, and engage the client for a period of greater than three months after persistent efforts by the ACT team to locate the client; or

(7) the client requests a discharge, despite repeated and proactive efforts by the ACT team to engage the client in service planning. The ACT team must develop a transition plan to arrange for alternate treatment for clients in this situation who have a history of suicide attempts, assault, or forensic involvement.

(c) For all clients who are discharged from assertive community treatment to another service provider within the ACT team's service area there is a three-month transfer period, from the date of discharge, during which a client who does not adjust well to the new service, may voluntarily return to the ACT team. During this period, the ACT team must maintain contact with the client's new service provider.

Subd. 3. MS 2020 [Repealed, 2021 c 30 art 17 s 113]

Subd. 3a. **Provider certification and contract requirements for assertive community treatment.** (a) The assertive community treatment provider must have each ACT team be certified by the state following the certification process and procedures developed by the commissioner. The certification process determines whether the ACT team meets the standards for assertive community treatment under this section, the standards in chapter 245I as required in section 245I.011, subdivision 5, and minimum program fidelity standards as measured by a nationally recognized fidelity tool approved by the commissioner. Recertification must occur at least every three years.

(b) An ACT team certified under this subdivision must meet the following standards:

(1) have capacity to recruit, hire, manage, and train required ACT team members;

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

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

(4) keep all necessary records required by law;

(5) be an enrolled Medicaid provider;

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

(7) ensure that overall treatment supervision to the ACT team is provided by a qualified member of the ACT team and is available during and after regular business hours and on weekends and holidays.

(c) The commissioner may intervene at any time and decertify an ACT team with cause. The commissioner shall establish a process for decertification of an ACT team and shall require corrective action, medical assistance repayment, or decertification of an ACT team that no longer meets the requirements in this section or that fails to meet the clinical quality standards or administrative standards provided by the commissioner in the application and certification process. The decertification is subject to appeal to the state.

Subd. 4. MS 2024 [Repealed, 2025 c 38 art 6 s 6]

Subd. 5. MS 2015 Supp [Repealed by amendment, 2016 c 163 art 2 s 5]

Subd. 5a. MS 2020 [Repealed, 2021 c 30 art 17 s 113]

Subd. 6. MS 2014 [Repealed by amendment, 2016 c 163 art 2 s 5]

Subd. 7. **Assertive community treatment service standards.** (a) ACT teams must offer and have the capacity to directly provide the following services:

(1) assertive engagement using collaborative strategies to encourage clients to receive services;

(2) benefits and finance support that assists clients to capably manage financial affairs. Services include but are not limited to assisting clients in applying for benefits, assisting with redetermination of benefits,

providing financial crisis management, teaching and supporting budgeting skills and asset development, and coordinating with a client's representative payee, if applicable;

(3) co-occurring substance use disorder treatment as defined in section 245I.02, subdivision 11;

(4) crisis assessment and intervention;

(5) employment services that assist clients to work at jobs of the clients' choosing. Services must follow the principles of the individual placement and support employment model, including focusing on competitive employment, emphasizing individual client preferences and strengths, ensuring employment services are integrated with mental health services, conducting rapid job searches and systematic job development according to client preferences and choices, providing benefits counseling, and offering all services in an individualized and time-unlimited manner. Services must also include educating clients about opportunities and benefits of work and school and assisting the client in learning job skills, navigating the workplace, workplace accommodations, and managing work relationships;

(6) family psychoeducation and support provided to the client's family and other natural supports to restore and strengthen the client's unique social and family relationships. Services include but are not limited to individualized psychoeducation about the client's illness and the role of the family and other significant people in the therapeutic process; family intervention to restore contact, resolve conflict, and maintain relationships with family and other significant people in the client's life; ongoing communication and collaboration between the ACT team and the family; introduction and referral to family self-help programs and advocacy organizations that promote recovery and family engagement, individual supportive counseling, parenting training, and service coordination to help clients fulfill parenting responsibilities; coordinating services for the child and restoring relationships with children who are not in the client's custody; and coordinating with child welfare and family agencies, if applicable. These services must be provided with the client's agreement and consent;

(7) housing access support that assists clients to find, obtain, retain, and move to safe and adequate housing of their choice. Housing access support includes but is not limited to locating housing options with a focus on integrated independent settings; applying for housing subsidies, programs, or resources; assisting the client in developing relationships with local landlords; providing tenancy support and advocacy for the individual's tenancy rights at the client's home; and assisting with relocation;

(8) medication assistance and support that assists clients in accessing medication, developing the ability to take medications with greater independence, and providing medication setup. Medication assistance and support includes assisting the client with the prescription, administration, and ordering of medication by appropriate medical staff;

(9) medication education that educates clients on the role and effects of medications in treating symptoms of mental illness and the side effects of medications;

(10) mental health certified peer specialists services according to section 256B.0615;

(11) physical health services to meet the physical health needs of the client to support the client's mental health recovery. Services include but are not limited to education on primary health and wellness issues, medication administration and monitoring, providing and coordinating medical screening and follow-up, scheduling routine and acute medical and dental care visits, tobacco cessation strategies, assisting clients in attending appointments, communicating with other providers, and integrating all physical and mental health treatment;

(12) rehabilitative mental health services as defined in section 245I.02, subdivision 33;

(13) symptom management that supports clients in identifying and targeting the symptoms and occurrence patterns of their mental illness and developing strategies to reduce the impact of those symptoms;

(14) therapeutic interventions to address specific symptoms and behaviors such as anxiety, psychotic symptoms, emotional dysregulation, and trauma symptoms. Interventions include empirically supported psychotherapies including but not limited to cognitive behavioral therapy, exposure therapy, acceptance and commitment therapy, interpersonal therapy, and motivational interviewing;

(15) wellness self-management and prevention that includes a combination of approaches to working with the client to build and apply skills related to recovery, and to support the client in participating in leisure and recreational activities, civic participation, and meaningful structure; and

(16) other services based on client needs as identified in a client's assertive community treatment individual treatment plan.

(b) ACT teams must ensure the provision of all services necessary to meet a client's needs as identified in the client's individual treatment plan.

Subd. 7a. **Assertive community treatment team staff requirements and roles.** (a) The required treatment staff qualifications and roles for an ACT team are:

(1) the team leader:

(i) must be a mental health professional, clinical trainee, or mental health practitioner;

(ii) must be an active member of the ACT team and provide some direct services to clients;

(iii) must be a single full-time staff member, dedicated to the ACT team, who is responsible for overseeing the administrative operations of the team and supervising team members to ensure delivery of best and ethical practices; and

(iv) must be available to ensure that overall treatment supervision to the ACT team is available after regular business hours and on weekends and holidays and is provided by a qualified member of the ACT team;

(2) the psychiatric care provider:

(i) must be a mental health professional permitted to prescribe psychiatric medications as part of the mental health professional's scope of practice. The psychiatric care provider must have demonstrated clinical experience working with individuals with serious and persistent mental illness;

(ii) shall collaborate with the team leader in sharing overall clinical responsibility for screening and admitting clients; monitoring clients' treatment and team member service delivery; educating staff on psychiatric and nonpsychiatric medications, their side effects, and health-related conditions; actively collaborating with nurses; and helping provide treatment supervision to the team;

(iii) shall fulfill the following functions for assertive community treatment clients: provide assessment and treatment of clients' symptoms and response to medications, including side effects; provide brief therapy to clients; provide diagnostic and medication education to clients, with medication decisions based on shared decision making; monitor clients' nonpsychiatric medical conditions and nonpsychiatric medications; and conduct home and community visits;

(iv) shall serve as the point of contact for psychiatric treatment if a client is hospitalized for mental health treatment and shall communicate directly with the client's inpatient psychiatric care providers to ensure continuity of care;

(v) shall have a minimum full-time equivalency that is prorated at a rate of 16 hours per 50 clients. Part-time psychiatric care providers shall have designated hours to work on the team, with sufficient blocks of time on consistent days to carry out the provider's clinical, supervisory, and administrative responsibilities. No more than two psychiatric care providers may share this role; and

(vi) shall provide psychiatric backup to the program after regular business hours and on weekends and holidays. The psychiatric care provider may delegate this duty to another qualified psychiatric provider;

(3) the nursing staff:

(i) shall consist of one to three registered nurses or advanced practice registered nurses, of whom at least one has a minimum of one-year experience working with adults with serious mental illness and a working knowledge of psychiatric medications. No more than two individuals can share a full-time equivalent position;

(ii) are responsible for managing medication, administering and documenting medication treatment, and managing a secure medication room; and

(iii) shall develop strategies, in collaboration with clients, to maximize taking medications as prescribed; screen and monitor clients' mental and physical health conditions and medication side effects; engage in health promotion, prevention, and education activities; communicate and coordinate services with other medical providers; facilitate the development of the individual treatment plan for clients assigned; and educate the ACT team in monitoring psychiatric and physical health symptoms and medication side effects;

(4) the co-occurring disorder specialist:

(i) shall be a full-time equivalent co-occurring disorder specialist who has received specific training on co-occurring disorders that is consistent with national evidence-based practices. The training must include practical knowledge of common substances and how they affect mental illnesses, the ability to assess substance use disorders and the client's stage of treatment, motivational interviewing, and skills necessary to provide counseling to clients at all different stages of change and treatment. The co-occurring disorder specialist may also be an individual who is a licensed alcohol and drug counselor as described in section 148F.01, subdivision 5, or a counselor who otherwise meets the training, experience, and other requirements in section 245G.11, subdivision 5. No more than two co-occurring disorder specialists may occupy this role; and

(ii) shall provide or facilitate the provision of co-occurring disorder treatment to clients. The co-occurring disorder specialist shall serve as a consultant and educator to fellow ACT team members on co-occurring disorders;

(5) the vocational specialist:

(i) shall be a full-time vocational specialist who has at least one-year experience providing employment services or advanced education that involved field training in vocational services to individuals with mental illness. An individual who does not meet these qualifications may also serve as the vocational specialist upon completing a training plan approved by the commissioner;

(ii) shall provide or facilitate the provision of vocational services to clients. The vocational specialist serves as a consultant and educator to fellow ACT team members on these services; and

(iii) must not refer individuals to receive any type of vocational services or linkage by providers outside of the ACT team;

(6) the mental health certified peer specialist:

(i) shall be a full-time equivalent. No more than two individuals can share this position. The mental health certified peer specialist is a fully integrated team member who provides highly individualized services in the community and promotes the self-determination and shared decision-making abilities of clients. This requirement may be waived due to workforce shortages upon approval of the commissioner;

(ii) must provide coaching, mentoring, and consultation to the clients to promote recovery, self-advocacy, and self-direction, promote wellness management strategies, and assist clients in developing advance directives; and

(iii) must model recovery values, attitudes, beliefs, and personal action to encourage wellness and resilience, provide consultation to team members, promote a culture where the clients' points of view and preferences are recognized, understood, respected, and integrated into treatment, and serve in a manner equivalent to other team members;

(7) the program administrative assistant shall be a full-time office-based program administrative assistant position assigned to solely work with the ACT team, providing a range of supports to the team, clients, and families; and

(8) additional staff:

(i) shall be based on team size. Additional treatment team staff may include mental health professionals; clinical trainees; certified rehabilitation specialists; mental health practitioners; or mental health rehabilitation workers. These individuals shall have the knowledge, skills, and abilities required by the population served to carry out rehabilitation and support functions; and

(ii) shall be selected based on specific program needs or the population served.

(b) Each ACT team must clearly document schedules for all ACT team members.

(c) Each ACT team member must serve as a primary team member for clients assigned by the team leader and are responsible for facilitating the individual treatment plan process for those clients. The primary team member for a client is the responsible team member knowledgeable about the client's life and circumstances and writes the individual treatment plan. The primary team member provides individual supportive therapy or counseling, and provides primary support and education to the client's family and support system.

(d) Members of the ACT team must have strong clinical skills, professional qualifications, experience, and competency to provide a full breadth of rehabilitation services. Each staff member shall be proficient in their respective discipline and be able to work collaboratively as a member of a multidisciplinary team to deliver the majority of the treatment, rehabilitation, and support services clients require to fully benefit from receiving assertive community treatment.

(e) Each ACT team member must fulfill training requirements established by the commissioner.

[See Note.]

Subd. 7b. **Assertive community treatment program scores.** Each ACT team must demonstrate that the team attained a passing score according to the most recently issued Tool for Measurement of Assertive Community Treatment (TMACT).

Subd. 7c. **Assertive community treatment program organization and communication requirements.** (a) An ACT team shall provide at least 75 percent of all services in the community in non-office-based or non-facility-based settings.

(b) ACT team members must know all clients receiving services, and interventions must be carried out with consistency and follow empirically supported practice.

(c) Each ACT team client shall be assigned an individual treatment team that is determined by a variety of factors, including team members' expertise and skills, rapport, and other factors specific to the individual's preferences. The majority of clients shall see at least three ACT team members in a given month.

(d) The ACT team shall have the capacity to rapidly increase service intensity to a client when the client's status requires it, regardless of geography, and provide flexible service in an individualized manner at a frequency that meets the client's needs. Services must be available at times that meet client needs.

(e) ACT teams shall make deliberate efforts to assertively engage clients in services. Input of family members, natural supports, and previous and subsequent treatment providers is required in developing engagement strategies. ACT teams shall include the client, identified family, and other support persons in the admission, initial assessment, and planning process as primary stakeholders, meet with the client in the client's environment at times of the day and week that honor the client's preferences, and meet clients at home and in jails or prisons, streets, homeless shelters, or hospitals.

(f) ACT teams shall ensure that a process is in place for identifying individuals in need of more or less assertive engagement. Interventions are monitored to determine the success of these techniques and the need to adapt the techniques or approach accordingly.

(g) ACT teams shall conduct daily team meetings to systematically update clinically relevant information, briefly discuss the status of assertive community treatment clients over the past 24 hours, problem solve emerging issues, plan approaches to address and prevent crises, and plan the service contacts for the following 24-hour period or weekend. All team members scheduled to work shall attend this meeting.

(h) ACT teams shall maintain a clinical log that succinctly documents important clinical information and develop a daily team schedule for the day's contacts based on a central file of the clients' weekly or monthly schedules, which are derived from interventions specified within the individual treatment plan. The team leader must have a record to ensure that all assigned contacts are completed.

Subd. 7d. **Assertive community treatment assessment and individual treatment plan.** (a) An initial assessment shall be completed the day of the client's admission to assertive community treatment by the ACT team leader or the psychiatric care provider, with participation by designated ACT team members and the client. The initial assessment must include obtaining or completing a standard diagnostic assessment according to section 245I.10, subdivision 6, and completing a 30-day individual treatment plan. The team leader, psychiatric care provider, or other mental health professional designated by the team leader or psychiatric care provider, must update the client's diagnostic assessment as required under section 245I.10, subdivision 2, paragraphs (f) and (g).

(b) A functional assessment must be completed according to section 245I.10, subdivision 9. Each part of the functional assessment areas shall be completed by each respective team specialist or an ACT team member with skill and knowledge in the area being assessed.

(c) Between 30 and 45 days after the client's admission to assertive community treatment, the entire ACT team must hold a comprehensive case conference, where all team members, including the psychiatric provider, present information discovered from the completed assessments and provide treatment recommendations. The conference must serve as the basis for the first individual treatment plan, which must be written by the primary team member.

(d) The client's psychiatric care provider, primary team member, and individual treatment team members shall assume responsibility for preparing the written narrative of the results from the psychiatric and social functioning history timeline and the comprehensive assessment.

(e) The primary team member and individual treatment team members shall be assigned by the team leader in collaboration with the psychiatric care provider by the time of the first treatment planning meeting or 30 days after admission, whichever occurs first.

(f) Individual treatment plans must be developed through the following treatment planning process:

(1) The individual treatment plan shall be developed in collaboration with the client and the client's preferred natural supports, and guardian, if applicable and appropriate. The ACT team shall evaluate, together with each client, the client's needs, strengths, and preferences and develop the individual treatment plan collaboratively. The ACT team shall make every effort to ensure that the client and the client's family and natural supports, with the client's consent, are in attendance at the treatment planning meeting, are involved in ongoing meetings related to treatment, and have the necessary supports to fully participate. The client's participation in the development of the individual treatment plan shall be documented.

(2) The client and the ACT team shall work together to formulate and prioritize the issues, set goals, research approaches and interventions, and establish the plan. The plan is individually tailored so that the treatment, rehabilitation, and support approaches and interventions achieve optimum symptom reduction, help fulfill the personal needs and aspirations of the client, take into account the cultural beliefs and realities of the individual, and improve all the aspects of psychosocial functioning that are important to the client. The process supports strengths, rehabilitation, and recovery.

(3) Each client's individual treatment plan shall identify service needs, strengths and capacities, and barriers, and set specific and measurable short- and long-term goals for each service need. The individual treatment plan must clearly specify the approaches and interventions necessary for the client to achieve the individual goals, when the interventions shall happen, and identify which ACT team member shall carry out the approaches and interventions.

(4) The primary team member and the individual treatment team, together with the client and the client's family and natural supports with the client's consent, are responsible for reviewing and rewriting the treatment goals and individual treatment plan whenever there is a major decision point in the client's course of treatment or at least every six months.

(5) The primary team member shall prepare a summary that thoroughly describes in writing the client's and the individual treatment team's evaluation of the client's progress and goal attainment, the effectiveness of the interventions, and the satisfaction with services since the last individual treatment plan. The client's most recent diagnostic assessment must be included with the treatment plan summary.

(6) The individual treatment plan and review must be approved or acknowledged by the client, the primary team member, the team leader, the psychiatric care provider, and all individual treatment team members. A copy of the approved individual treatment plan must be made available to the client.

Subd. 7e. **ACT team variances.** The commissioner may grant a variance to specific requirements under subdivision 2a, 7a, 7b, or 7c for an ACT team when the ACT team demonstrates an inability to meet the specific requirement and how the team shall ensure the variance shall not negatively impact outcomes for clients. The commissioner may require a plan of action for the ACT team to come into compliance with the specific requirement being varied and establish specific time limits for the variance. A decision to grant or deny a variance request is final and not subject to appeal.

Subd. 8. **Medical assistance payment for assertive community treatment services.** (a) Payment for assertive community treatment in this section shall be based on one daily rate per provider inclusive of the following services received by an eligible client 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 (d), payment will 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 must determine how to distribute the payment among the members.

(c) Payment under this section must only be provided if the client is eligible for the service and the service is determined to be medically necessary.

(d) The commissioner shall determine one rate for each assertive community treatment provider under this section. If a single entity provides both intensive residential treatment services under section 256B.0632 and assertive community treatment under this section, one rate is established for the entity's intensive residential treatment services under section 256B.0632 and another rate for the entity's assertive community treatment 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 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) physical plant costs calculated based on the percentage of space within the program that is entirely devoted to treatment and programming. This does not include administrative or residential space;

(iv) assertive community treatment physical plant costs must be reimbursed as part of the costs described in item (ii); and

(v) subject to federal approval, up to an additional five percent of the total rate may be added to the program rate as a quality incentive based upon the entity meeting performance criteria specified by the commissioner;

(2) actual costs are 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 Uniform Guidance under Code of Federal Regulations, title 2, section 200, relating to nonprofit entities;

(3) the number of service units;

(4) the degree to which clients will receive services other than services under this section or section 256B.0632; and

(5) the costs of other services that will be separately reimbursed.

(e) The rate for assertive community treatment must exclude the medical assistance room and board rate, as defined in section 256B.056, subdivision 5d, and services not covered under this section, such as partial hospitalization, home care, and inpatient services.

(f) When services under this section are provided by an assertive community treatment provider, case management functions must be an integral part of the team.

(g) The rate for a provider must not exceed the rate charged by that provider for the same service to other payors.

(h) 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 (d). The rates for new programs must be established based upon estimated expenditures and estimated utilization using the criteria established in paragraph (d).

(i) Effective for the rate years beginning on and after January 1, 2024, rates for assertive community treatment, adult residential crisis stabilization services, and intensive residential treatment services must be annually adjusted for inflation using the Centers for Medicare and Medicaid Services Medicare Economic Index, as forecasted in the third quarter of the calendar year before the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined. This paragraph expires upon federal approval.

(j) Effective upon the expiration of paragraph (i), and effective for the rate years beginning on and after January 1, 2024, rates for assertive community treatment services must be annually adjusted for inflation using the Centers for Medicare and Medicaid Services Medicare Economic Index, as forecasted in the third quarter of the calendar year before the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined.

(k) 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 and must reflect a difference of greater than five percent.

(l) A provider may request of the commissioner a review of any rate-setting decision made under this subdivision.

[See Note.]

Subd. 8a. MS 2010 [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.

Subd. 10. **Provider enrollment; rate setting for specialized program.** A county contract is not required for a provider proposing to serve a subpopulation of eligible clients 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.

Subd. 11. **Sustainability grants.** The commissioner may disburse grant funds directly to assertive community treatment providers to maintain access to these services.

Subd. 12. **Start-up grants.** The commissioner may, within available appropriations, disburse grant funding to counties, Indian Tribes, or mental health service providers to establish additional assertive community treatment teams.

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; 2015 c 71 art 2 s 23-32; 2016 c 163 art 2 s 5; 2016 c 189 art 16 s 11; 2017 c 40 art 1 s 67,68; 2018 c 128 s 5; 2018 c 151 s 1; 2018 c 182 art 2 s 19; 2020 c 115 art 4 s 113; 2021 c 30 art 17 s 55-62; 1Sp2021 c 7 art 6 s 10,28; 2022 c 58 s 137; 2022 c 98 art 4 s 31; 2023 c 70 art 1 s 10; art 9 s 28,29; art 17 s 42; 2024 c 125 art 4 s 6; 2024 c 127 art 49 s 6; art 55 s 7; art 61 s 15-19; 2025 c 38 art 4 s 37,38; art 6 s 1-4*

NOTE: The amendment to subdivision 7a by Laws 2025, chapter 38, article 4, section 38, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2025, chapter 38, article 4, section 38, the effective date.

NOTE: The amendment to subdivision 8 by Laws 2023, chapter 70, article 1, section 10, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2023, chapter 70, article 1, section 10, the effective date.

256B.0623 ADULT REHABILITATIVE MENTAL HEALTH SERVICES COVERED.

Subdivision 1. **Scope.** Medical assistance covers medically necessary adult rehabilitative mental health services when the services are provided by an entity licensed under section 245I.24. The provider entity must make reasonable and good faith efforts to report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner.

[See Note.]

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

(a) "Adult rehabilitative mental health services" means the services described in section 245I.02, subdivision 33.

(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, advanced practice registered nurses, 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, 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.

[See Note.]

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

(1) is age 18 or older;

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

(3) has substantial disability and functional impairment in three or more of the areas listed in section 245I.10, subdivision 9, paragraph (a), clause (4), so that self-sufficiency is markedly reduced; and

(4) has had a recent standard diagnostic assessment pursuant to section 245I.10, subdivision 6, 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.

[See Note.]

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 section and chapter 245I, as required in section 245I.011, subdivision 5. The certification must specify which adult rehabilitative mental health services the entity is qualified to provide.

(c) State-level recertification must occur at least every three years.

(d) 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.

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

(1) have capacity to recruit, hire, manage, and train qualified staff;

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

(3) ensure that staff are skilled in the delivery of the specific adult rehabilitative mental health services provided to the individual eligible recipient;

(4) 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;

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

(6) ensure that services are coordinated with other recipient mental health services providers and the county mental health authority and the federally recognized American Indian authority and necessary others

after obtaining the consent of the recipient. Services must also be coordinated with the recipient's case manager or care coordinator if the recipient is receiving case management or care coordination services;

(7) keep all necessary records required by law;

(8) deliver services as required by section 245.461;

(9) be an enrolled Medicaid provider; and

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

[See Note.]

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 as:

(1) a mental health professional who is qualified according to section 245I.04, subdivision 2;

(2) a certified rehabilitation specialist who is qualified according to section 245I.04, subdivision 8;

(3) a clinical trainee who is qualified according to section 245I.04, subdivision 6;

(4) a mental health practitioner qualified according to section 245I.04, subdivision 4;

(5) a mental health certified peer specialist who is qualified according to section 245I.04, subdivision 10;

(6) a mental health rehabilitation worker who is qualified according to section 245I.04, subdivision 14; or

(7) a licensed occupational therapist, as defined in section 148.6402, subdivision 14.

[See Note.]

Subd. 6. **Required supervision.** (a) A treatment supervisor providing treatment supervision required by section 245I.06 must:

(1) meet with staff receiving treatment supervision at least monthly to discuss treatment topics of interest and treatment plans of recipients; and

(2) meet at least monthly with the directing clinical trainee or 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 clinical trainee or mental health practitioner.

(b) A treatment supervisor providing treatment supervision required by section 245I.06 must complete an attestation form in a manner provided by the commissioner. This form must be completed at least annually, and updated upon any change in the number of organizations the treatment supervisor is affiliated with under this section or section 256B.0943. The attestation must include:

(1) the total number of staff and full-time equivalent staff the treatment supervisor supervises, across all programs under this section and section 256B.0943, which must not exceed 20 full-time equivalent staff; and

(2) the name and national provider identifier of each organization for which the treatment supervisor provides supervision under this section or section 256B.0943, which must not exceed ten organizations.

(c) The commissioner may grant an exception to the limitations in paragraph (b), clauses (1) and (2). The commissioner must develop criteria and a standardized process for evaluating exception requests and may rescind approval of an exception if the treatment supervisor fails to comply with applicable program standards.

(d) An adult rehabilitative mental health services provider entity must have a treatment director who is a mental health professional, clinical trainee, certified rehabilitation specialist, or mental health practitioner. The treatment director must:

(1) ensure the direct observation of mental health rehabilitation workers required by section 245I.06, subdivision 3, is provided;

(2) ensure immediate availability by phone or in person for consultation by a mental health professional, certified rehabilitation specialist, clinical trainee, or a mental health practitioner to the mental health rehabilitation worker during service provision;

(3) 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;

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

(5) oversee the record of the results of direct observation, progress note evaluation, and corrective actions taken to modify the work of the clinical trainees, mental health practitioners, and mental health rehabilitation workers.

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

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

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

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

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

[See Note.]

Subd. 7. MS 2020 [Repealed, 2021 c 30 art 17 s 113]

Subd. 8. MS 2020 [Repealed, 2021 c 30 art 17 s 113]

Subd. 9. **Functional assessment.** (a) Providers of adult rehabilitative mental health services must complete a written functional assessment according to section 245I.10, subdivision 9, for each recipient.

(b) When a provider of adult rehabilitative mental health services completes a written functional assessment, the provider must also complete a level of care assessment as defined in section 245I.02, subdivision 19, for the recipient.

[See Note.]

Subd. 10. MS 2020 [Repealed, 2021 c 30 art 17 s 113]

Subd. 11. MS 2020 [Repealed, 2021 c 30 art 17 s 113]

Subd. 12. **Additional requirements.** (a) 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 section 245I.23, or an acute care hospital.

(b) 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.

(c) Adult rehabilitative mental health services are appropriate if provided to enable a recipient to retain stability and functioning, when the recipient is at risk of significant functional decompensation or requiring more restrictive service settings without these services.

[See Note.]

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

(1) recipient transportation services;

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

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

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

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

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

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

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

(9) outreach services to potential recipients;

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

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

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

Subd. 15. **Billing limits.** Effective January 1, 2027, services under this section must not exceed four hours per week per recipient, with a maximum of 18 hours per month. Prior authorization is required for services exceeding 200 hours per year.

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; 2018 c 128 s 6; 2020 c 115 art 4 s 114; 2021 c 30 art 17 s 63-70; 2022 c 98 art 17 s 26; 2023 c 70 art 9 s 30; 2024 c 127 art 61 s 20; 2026 c 95 art 5 s 24; 2026 c 121 art 6 s 15; art 7 s 42-44*

NOTE: The amendments to subdivisions 1, 3, and 12 by Laws 2026, chapter 121, article 7, sections 42 to 44, are effective January 1, 2028. Laws 2026, chapter 121, article 7, section 56.

NOTE: Subdivisions 2, 4, 5, 6, and 9 are repealed by Laws 2026, chapter 121, article 7, section 55, effective January 1, 2028. Laws 2026, chapter 121, article 7, section 56.

256B.0624 CRISIS RESPONSE SERVICES COVERED.

Subdivision 1. **Scope.** (a) Medical assistance covers medically necessary crisis response services when the services are provided according to the standards in section 245I.24.

(b) Medical assistance covers medically necessary residential crisis stabilization for adults when the services are provided by an entity licensed under and meeting the standards in section 245I.23 or an entity with an adult foster care license meeting the standards in subdivision 7a.

(c) The provider entity must make reasonable and good faith efforts to report individual client outcomes to the commissioner using instruments and protocols approved by the commissioner.

[See Note.]

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

(a) "Certified rehabilitation specialist" means a staff person who is qualified under section 245I.04, subdivision 8.

(b) "Clinical trainee" means a staff person who is qualified under section 245I.04, subdivision 6.

(c) "Crisis assessment" means an immediate face-to-face assessment by a physician, a mental health professional, or a qualified member of a crisis team, as described in subdivision 6a.

(d) "Crisis intervention" means face-to-face, short-term intensive mental health services initiated during a mental health crisis 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.

(e) "Crisis screening" means a screening of a client's potential mental health crisis situation under subdivision 6.

(f) "Crisis stabilization" means individualized mental health services provided to a recipient that are designed to restore the recipient to the recipient's prior functional level. 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, a short-term supervised, licensed residential program, or an emergency department. Crisis stabilization services includes family psychoeducation.

(g) "Crisis team" means the staff of a provider entity who are supervised and prepared to provide mobile crisis services to a client in a potential mental health crisis situation.

(h) "Mental health certified family peer specialist" means a staff person who is qualified under section 245I.04, subdivision 12.

(i) "Mental health certified peer specialist" means a staff person who is qualified under section 245I.04, subdivision 10.

(j) "Mental health crisis" is a behavioral, emotional, or psychiatric situation that, without the provision of crisis response services, would likely result in significantly reducing the recipient's levels of functioning in primary activities of daily living, in an emergency situation under section 62Q.55, or in the placement of the recipient in a more restrictive setting, including but not limited to inpatient hospitalization.

(k) "Mental health practitioner" means a staff person who is qualified under section 245I.04, subdivision 4.

(l) "Mental health professional" means a staff person who is qualified under section 245I.04, subdivision 2.

(m) "Mental health rehabilitation worker" means a staff person who is qualified under section 245I.04, subdivision 14.

(n) "Mobile crisis services" means screening, assessment, intervention, and community-based stabilization, excluding residential crisis stabilization, that is provided to a recipient.

[See Note.]

Subd. 3. **Eligibility.** (a) A recipient is eligible for crisis assessment services when the recipient has screened positive for a potential mental health crisis during a crisis screening.

(b) A recipient is eligible for crisis intervention services and crisis stabilization services when the recipient has been assessed during a crisis assessment to be experiencing a mental health crisis.

[See Note.]

Subd. 4. **Provider entity standards.** (a) A mobile crisis provider must be:

(1) a county board operated entity;

(2) an Indian health services facility or facility owned and operated by a Tribe or Tribal organization operating under United States Code, title 325, section 450f; or

(3) 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) A mobile crisis provider must ensure services are provided consistent with section 245.469, subdivisions 1 and 2.

[See Note.]

Subd. 4a. **Alternative provider standards.** If a county or Tribe 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), the commissioner may approve an alternative plan proposed by a county or Tribe. The alternative plan must:

(1) result in increased access and a reduction in disparities in the availability of mobile crisis services;

(2) provide mobile crisis 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.

[See Note.]

Subd. 5. **Crisis assessment and intervention staff qualifications.** (a) Qualified individual staff of a qualified provider entity must provide crisis assessment and intervention services to a recipient. A staff member providing crisis assessment and intervention services to a recipient must be qualified as a:

(1) mental health professional;

(2) clinical trainee;

(3) mental health practitioner;

(4) mental health certified family peer specialist; or

(5) mental health certified peer specialist.

(b) When crisis assessment and intervention services are provided to a recipient in the community, a mental health professional, clinical trainee, or mental health practitioner must lead the response.

(c) The 30 hours of ongoing training required by section 245I.05, subdivision 4, paragraph (b), must be specific to providing crisis services to children and adults and include training about evidence-based practices identified by the commissioner of health to reduce the recipient's risk of suicide and self-injurious behavior.

(d) At least six hours of the ongoing training under paragraph (c) must be specific to working with families and providing crisis stabilization services to children and include the following topics:

(1) developmental tasks of childhood and adolescence;

(2) family relationships;

(3) child and youth engagement and motivation, including motivational interviewing;

(4) culturally responsive care, including care for lesbian, gay, bisexual, transgender, and queer youth;

(5) positive behavior support;

(6) crisis intervention for youth with developmental disabilities;

(7) child traumatic stress, trauma-informed care, and trauma-focused cognitive behavioral therapy; and

(8) youth substance use.

(e) Team members must be experienced in crisis 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.

[See Note.]

Subd. 6. **Crisis screening.** (a) The crisis screening may use the resources of emergency services as defined in section 245.469, subdivisions 1 and 2. The crisis screening must gather information, determine whether a mental health crisis situation exists, identify parties involved, and determine an appropriate response.

(b) When conducting the crisis screening of a recipient, a provider must:

(1) employ evidence-based practices to reduce the recipient's risk of suicide and self-injurious behavior;

(2) work with the recipient to establish a plan and time frame for responding to the recipient's mental health crisis, including responding to the recipient's immediate need for support by telephone or text message until the provider can respond to the recipient face-to-face;

(3) document significant factors in determining whether the recipient is experiencing a mental health crisis, including prior requests for crisis services, a recipient's recent presentation at an emergency department, known calls to 911 or law enforcement, or information from third parties with knowledge of a recipient's history or current needs;

(4) accept calls from interested third parties and consider the additional needs or potential mental health crises that the third parties may be experiencing;

(5) provide psychoeducation, including means reduction, to relevant third parties including family members or other persons living with the recipient; and

(6) consider other available services to determine which service intervention would best address the recipient's needs and circumstances.

(c) For the purposes of this section, the following situations indicate a positive screen for a potential mental health crisis and the provider must prioritize providing a face-to-face crisis assessment of the recipient, unless a provider documents specific evidence to show why this was not possible, including insufficient staffing resources, concerns for staff or recipient safety, or other clinical factors:

(1) the recipient presents at an emergency department or urgent care setting and the health care team at that location requested crisis services; or

(2) a peace officer requested crisis services for a recipient who is potentially subject to transportation under section 253B.051.

(d) A provider is not required to have direct contact with the recipient to determine that the recipient is experiencing a potential mental health crisis. A mobile crisis provider may gather relevant information about the recipient from a third party to establish the recipient's need for services and potential safety factors.

[See Note.]

Subd. 6a. **Crisis assessment.** (a) If a recipient screens positive for a potential mental health crisis, a crisis assessment must be completed. A crisis assessment evaluates any immediate needs for which services are needed and, as time permits, the recipient's current life situation, health information, including current

medications, 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 crisis treatment plan described under subdivision 11, a crisis prevention plan, or a wellness recovery action plan.

(b) A provider must conduct a crisis assessment at the recipient's location whenever possible.

(c) Whenever possible, the assessor must attempt to include input from the recipient and the recipient's family and other natural supports to assess whether a crisis exists.

(d) A crisis assessment includes: (1) determining (i) whether the recipient is willing to voluntarily engage in treatment, or (ii) whether the recipient has an advance directive, and (2) gathering the recipient's information and history from involved family or other natural supports.

(e) A crisis assessment must include coordinated response with other health care providers if the assessment indicates that a recipient needs detoxification, withdrawal management, or medical stabilization in addition to crisis response services. If the recipient does not need an acute level of care, a team must serve an otherwise eligible recipient who has a co-occurring substance use disorder.

(f) If, after completing a crisis assessment of a recipient, a provider refers a recipient to an intensive setting, including an emergency department, inpatient hospitalization, or residential crisis stabilization, one of the crisis team members who completed or conferred about the recipient's crisis assessment must immediately contact the referral entity and consult with the triage nurse or other staff responsible for intake at the referral entity. During the consultation, the crisis team member must convey key findings or concerns that led to the recipient's referral. Following the immediate consultation, the provider must also send written documentation upon completion. The provider must document if these releases occurred with authorization by the recipient, the recipient's legal guardian, or as allowed by section 144.293, subdivision 5.

[See Note.]

Subd. 6b. **Crisis intervention services.** (a) If the crisis assessment determines mobile crisis intervention services are needed, the crisis 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 crisis assessment, crisis treatment plan, and actions taken and needed. At least one of the team members must be providing face-to-face crisis intervention services. If providing crisis intervention services, a clinical trainee or mental health practitioner must seek treatment supervision as required in subdivision 9.

(b) If a provider delivers crisis intervention services while the recipient is absent, the provider must document the reason for delivering services while the recipient is absent.

(c) The mobile crisis intervention team must develop a crisis treatment plan according to subdivision 11.

(d) The mobile crisis intervention team must document which crisis treatment plan goals and objectives have been met and when no further crisis intervention services are required.

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

services must be coordinated with the case manager. 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.

[See Note.]

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 treatment plan must be developed that meets the criteria in subdivision 11;

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

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

(4) if a provider delivers crisis stabilization services while the recipient is absent, the provider must document the reason for delivering services while the recipient is absent; and

(5) for a recipient who is 18 years of age or older, the case manager or crisis team must offer to work with the recipient to develop a health care directive, as defined in section 145C.01, subdivision 5a, or a declaration of preferences under section 253B.03, subdivision 6d, if the recipient's mental health crisis is stabilized and the recipient does not have a directive or declaration.

(b) If crisis stabilization services are provided in a supervised, licensed residential setting that serves no more than four adult residents, and one or more individuals are present at the setting to receive residential crisis stabilization, the residential staff must include, for at least eight hours per day, at least one mental health professional, clinical trainee, certified rehabilitation specialist, or mental health practitioner. The commissioner must establish a statewide per diem rate for crisis stabilization services provided under this paragraph to medical assistance enrollees. The rate for a provider must not exceed the rate charged by that provider for the same service to other payers. Payment must not be made to more than one entity for each individual for services provided under this paragraph on a given day. The commissioner must set rates prospectively for the annual rate period. The commissioner must require providers to submit annual cost reports on a uniform cost reporting form and must use submitted cost reports to inform the rate-setting process. The commissioner must recalculate the statewide per diem every year.

[See Note.]

Subd. 7a. **Residential crisis stabilization services in adult foster care settings.** (a) If crisis stabilization services are provided in a supervised, licensed residential setting that serves no more than four adult residents, and one or more individuals are present at the setting to receive residential crisis stabilization, the residential setting staff must include, for at least eight hours per day, at least one mental health professional, clinical trainee, certified rehabilitation specialist, or mental health practitioner.

(b) The commissioner must establish a statewide per diem rate for crisis stabilization services provided under this paragraph to medical assistance enrollees. The rate for a provider must not exceed the rate charged by that provider for the same service to other payers. Payment must not be made to more than one entity for each individual for services provided under this paragraph on a given day. The commissioner must set rates prospectively for the annual rate period. The commissioner must require providers to submit annual cost reports on a uniform cost reporting form and use submitted cost reports to inform the rate-setting process. The commissioner must recalculate the statewide per diem every year.

(c) A provider under this subdivision must follow the requirements under section 245I.24, subdivisions 4, paragraphs (c) and (d), and 9.

[See Note.]

Subd. 8. **Crisis stabilization staff qualifications.** (a) Mental health crisis stabilization services must be provided by qualified individual staff of a qualified provider entity. A staff member providing crisis stabilization services to a recipient must be qualified as a:

(1) mental health professional;

(2) certified rehabilitation specialist;

(3) clinical trainee;

(4) mental health practitioner;

(5) mental health certified family peer specialist;

(6) mental health certified peer specialist; or

(7) mental health rehabilitation worker.

(b) The 30 hours of ongoing training required in section 245I.05, subdivision 4, paragraph (b), must be specific to providing crisis services to children and adults and include training about evidence-based practices identified by the commissioner of health to reduce a recipient's risk of suicide and self-injurious behavior.

(c) For providers who deliver care to children 21 years of age and younger, at least six hours of the ongoing training under this subdivision must be specific to working with families and providing crisis stabilization services to children and include the following topics:

(1) developmental tasks of childhood and adolescence;

(2) family relationships;

(3) child and youth engagement and motivation, including motivational interviewing;

(4) culturally responsive care, including care for lesbian, gay, bisexual, transgender, and queer youth;

(5) positive behavior support;

(6) crisis intervention for youth with developmental disabilities;

(7) child traumatic stress, trauma-informed care, and trauma-focused cognitive behavioral therapy; and

(8) youth substance use.

This paragraph does not apply to adult residential crisis stabilization service providers licensed according to section 245I.23.

[See Note.]

Subd. 9. **Supervision.** Clinical trainees and mental health practitioners may provide crisis assessment and crisis intervention services if the following treatment 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 must be immediately available by phone or in person for treatment supervision;

(3) the mental health professional is consulted, in person or by phone, during the first three hours when a clinical trainee or mental health practitioner provides crisis assessment or crisis intervention services; and

(4) the mental health professional must:

(i) review and approve, as defined in section 245I.02, subdivision 2, of the tentative crisis assessment and crisis treatment plan within 24 hours of first providing services to the recipient, notwithstanding section 245I.08, subdivision 3; and

(ii) document the consultation required in clause (3).

[See Note.]

Subd. 10. MS 2020 [Repealed, 2021 c 30 art 16 s 4]

Subd. 11. **Crisis treatment plan.** (a) Within 24 hours of the recipient's admission, the provider entity must complete the recipient's crisis treatment plan. The provider entity must:

(1) base the recipient's crisis treatment plan on the recipient's crisis assessment;

(2) consider crisis assistance strategies that have been effective for the recipient in the past;

(3) for a child recipient, use a child-centered, family-driven, and culturally appropriate planning process that allows the recipient's parents and guardians to observe or participate in the recipient's individual and family treatment services, assessment, and treatment planning;

(4) for an adult recipient, use a person-centered, culturally appropriate planning process that allows the recipient's family and other natural supports to observe or participate in treatment services, assessment, and treatment planning;

(5) identify the participants involved in the recipient's treatment planning. The recipient, if possible, must be a participant;

(6) identify the recipient's initial treatment goals, measurable treatment objectives, and specific interventions that the license holder will use to help the recipient engage in treatment;

(7) include documentation of referral to and scheduling of services, including specific providers where applicable;

(8) ensure that the recipient or the recipient's legal guardian approves under section 245I.02, subdivision 2, of the recipient's crisis treatment plan unless a court orders the recipient's treatment plan under chapter 253B. If the recipient or the recipient's legal guardian disagrees with the crisis treatment plan, the license holder must document in the client file the reasons why the recipient disagrees with the crisis treatment plan; and

(9) ensure that a treatment supervisor approves under section 245I.02, subdivision 2, of the recipient's treatment plan within 24 hours of the recipient's admission if a mental health practitioner or clinical trainee completes the crisis treatment plan, notwithstanding section 245I.08, subdivision 3.

(b) The provider entity must provide the recipient and the recipient's legal guardian with a copy of the recipient's crisis treatment plan.

[See Note.]

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

(1) room and board services;

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

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

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

(5) services performed by volunteers;

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

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

(8) outreach services to potential recipients;

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

(10) services that a residential treatment center licensed under Minnesota Rules, chapter 2960, provides to a client;

(11) partial hospitalization or day treatment; and

(12) a crisis assessment that a residential provider completes when a daily rate is paid for the recipient's crisis stabilization.

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; 2015 c 71 art 2 s 33; 2018 c 151 s 2; 2021 c 30 art 16 s 4; 1Sp2021 c 7 art 11 s 16; 2023 c 70 art 9 s 31,32; 2026 c 88 art 1 s 123; 2026 c 95 art 5 s 25,26; 2026 c 121 art 7 s 45-47*

NOTE: The amendments to subdivisions 1 and 4 by Laws 2026, chapter 121, article 7, sections 45 and 46, are effective January 1, 2028. Laws 2026, chapter 121, article 7, section 56.

NOTE: Subdivisions 2, 3, 4a, 5, 6, 6a, 6b, 7, 8, 9, and 11 are repealed by Laws 2026, chapter 121, article 7, section 55, effective January 1, 2028. Laws 2026, chapter 121, article 7, section 56.

NOTE: The amendment to subdivision 6b by Laws 2026, chapter 95, article 5, section 25, is effective upon federal approval. Laws 2026, chapter 95, article 5, section 25, the effective date.

NOTE: The amendment to subdivision 7 by Laws 2026, chapter 95, article 5, section 26, is effective upon federal approval. Laws 2026, chapter 95, article 5, section 26, the effective date.

NOTE: Subdivision 7a, as added by Laws 2026, chapter 121, article 7, section 47, is effective January 1, 2028. Laws 2026, chapter 121, article 7, section 56.

256B.0625 COVERED SERVICES.

Subdivision 1. **Inpatient hospital services.** (a) Medical assistance covers inpatient hospital services performed by hospitals holding Medicare certifications for the services performed.

(b) When determining medical necessity for inpatient hospital services, the medical review agent shall follow industry standard medical necessity criteria in determining the following:

(1) whether a recipient's admission is medically necessary;

(2) whether the inpatient hospital services provided to the recipient were medically necessary;

(3) whether the recipient's continued stay was or will be medically necessary; and

(4) whether all medically necessary inpatient hospital services were provided to the recipient.

The medical review agent will determine medical necessity of inpatient hospital services, including inpatient psychiatric treatment, based on a review of the patient's medical condition and records, in conjunction with industry standard evidence-based criteria to ensure consistent and optimal application of medical appropriateness criteria.

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.** 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.

[See Note.]

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.

Subd. 2b. **Nursing care provided to a patient in a swing bed.** (a) 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 25 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.

(b) The commissioner shall exempt a facility from compliance with the sole community provider requirement in paragraph (a), clause (1), if, as of January 1, 2004, the facility had an agreement with the commissioner to provide medical assistance swing bed services.

(c) 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, advanced practice registered nurse, or physician assistant 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.

(d) The commissioner shall exempt any facility described under section 144.5621 from compliance with the requirements of paragraph (a), clauses (3) and (5), and paragraph (c), and medical assistance covers an unlimited number of days of nursing care provided to a patient in a swing bed at a facility described under section 144.5621.

(e) 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.

[See Note.]

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.

(f) A physician shall not bill a recipient of services for any payment disallowed under this subdivision.

Subd. 3a. **Gender-affirming care.** Medical assistance covers gender-affirming care, as defined in section 62Q.585.

Subd. 3b. **Telehealth services.** (a) Medical assistance covers medically necessary services and consultations delivered by a health care provider through telehealth in the same manner as if the service or consultation was delivered through in-person contact. Services or consultations delivered through telehealth shall be paid at the full allowable rate.

(b) The commissioner may establish criteria that a health care provider must attest to in order to demonstrate the safety or efficacy of delivering a particular service through telehealth. The attestation may include that the health care provider:

(1) has identified the categories or types of services the health care provider will provide through telehealth;

(2) has written policies and procedures specific to services delivered through telehealth that are regularly reviewed and updated;

(3) has policies and procedures that adequately address patient safety before, during, and after the service is delivered through telehealth;

(4) has established protocols addressing how and when to discontinue telehealth services; and

(5) has an established quality assurance process related to delivering services through telehealth.

(c) As a condition of payment, a licensed health care provider must document each occurrence of a health service delivered through telehealth to a medical assistance enrollee. Health care service records for services delivered through telehealth must meet the requirements set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must document:

(1) the type of service delivered through telehealth;

(2) the time the service began and the time the service ended, including an a.m. and p.m. designation;

(3) the health care provider's basis for determining that telehealth is an appropriate and effective means for delivering the service to the enrollee;

(4) the mode of transmission used to deliver the service through telehealth and records evidencing that a particular mode of transmission was utilized;

(5) the location of the originating site and the distant site;

(6) if the claim for payment is based on a physician's consultation with another physician through telehealth, the written opinion from the consulting physician providing the telehealth consultation; and

(7) compliance with the criteria attested to by the health care provider in accordance with paragraph (b).

(d) Telehealth visits provided through audio and visual communication or accessible video-based platforms may be used to satisfy the face-to-face requirement for reimbursement under the payment methods that apply to a federally qualified health center, rural health clinic, Indian health service, 638 Tribal clinic, and certified community behavioral health clinic, if the service would have otherwise qualified for payment if performed in person.

(e) For purposes of this subdivision, unless otherwise covered under this chapter:

(1) "telehealth" means the delivery of health care services or consultations using real-time two-way interactive audio and visual communication or accessible telehealth video-based platforms to provide or

support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care. Telehealth includes: the application of secure video conferencing consisting of a real-time, full-motion synchronized video; store-and-forward technology; and synchronous interactions, between a patient located at an originating site and a health care provider located at a distant site. Telehealth does not include communication between health care providers, or between a health care provider and a patient that consists solely of an audio-only communication, email, or facsimile transmission or as specified by law, except that from July 1, 2025, to July 1, 2027, telehealth includes communication between a health care provider and a patient that solely consists of audio-only communication;

(2) "health care provider" means a health care provider as defined under section 62A.673; a community paramedic as defined under section 144E.001, subdivision 5f; a community health worker who meets the criteria under subdivision 49, paragraph (a); a mental health certified peer specialist under section 245I.04, subdivision 10; a mental health certified family peer specialist under section 245I.04, subdivision 12; a mental health rehabilitation worker under section 245I.04, subdivision 14; a mental health behavioral aide under section 245I.04, subdivision 16; a treatment coordinator under section 245G.11, subdivision 7; an alcohol and drug counselor under section 245G.11, subdivision 5; or a recovery peer under section 245G.11, subdivision 8; and

(3) "originating site," "distant site," and "store-and-forward technology" have the meanings given in section 62A.673, subdivision 2.

[See Note.]

Subd. 3c. **Health Services Advisory Council.** (a) The commissioner, after receiving recommendations from professional physician associations, professional associations representing licensed nonphysician health care professionals, and consumer groups, shall establish a 14-member Health Services Advisory Council, which consists of 13 voting members and one nonvoting member. The Health Services Advisory Council shall advise the commissioner regarding (1) health services pertaining to the administration of health care benefits covered under Minnesota health care programs (MHCP); and (2) evidence-based decision-making and health care benefit and coverage policies for MHCP. The Health Services Advisory Council shall consider available evidence regarding quality, safety, and cost-effectiveness when advising the commissioner. The Health Services Advisory Council shall meet at least quarterly. The Health Services Advisory Council shall annually select a 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 Advisory Council may 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 subcouncil to operate under the Health Services Advisory Council. The dental subcouncil consists of general dentists, dental specialists, safety net providers, dental hygienists, health plan company and county and public health representatives, health researchers, consumers, and a designee of the commissioner of health. The dental subcouncil 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.

(c) The Health Services Advisory Council may monitor and track the practice patterns of health care providers who serve MHCP recipients under fee-for-service, managed care, and county-based purchasing. The monitoring and tracking shall focus on services or specialties for which there is a high variation in utilization or quality across providers, or which are associated with high medical costs. The commissioner, based upon the findings of the Health Services Advisory Council, may notify providers whose practice patterns indicate below average quality or 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 these data available to the Health Services Advisory Council.

Subd. 3d. **Health Services Advisory Council members.** (a) The Health Services Advisory Council consists of:

(1) six voting members who are licensed physicians actively engaged in the practice of medicine in Minnesota, three of whom must represent health plans currently under contract to serve MHCP recipients;

(2) two voting members who are licensed 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 voting member who is a health care or mental health professional licensed or registered in the member's profession, actively engaged in the practice of the member's profession in Minnesota, and actively engaged in the treatment of persons with mental illness;

(5) two consumers who shall serve as voting members; and

(6) the commissioner's medical director who shall serve as a nonvoting member.

(b) Members of the Health Services Advisory Council shall not be employed by the state of Minnesota, except for the medical director. A quorum shall comprise a simple majority of the voting members. Vacant seats shall not count toward a quorum.

Subd. 3e. **Health Services Advisory Council terms and compensation.** 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 Advisory Council meetings as needed. An honorarium of $200 per meeting and reimbursement for mileage and parking shall be paid to each council member in attendance except the medical director. The Health Services Advisory Council 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.

(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. 3h. **Telemonitoring services.** (a) Medical assistance covers telemonitoring services if:

(1) the telemonitoring service is medically appropriate based on the recipient's medical condition or status;

(2) the recipient's health care provider has identified that telemonitoring services would likely prevent the recipient's admission or readmission to a hospital, emergency room, or nursing facility;

(3) the recipient is cognitively and physically capable of operating the monitoring device or equipment, or the recipient has a caregiver who is willing and able to assist with the monitoring device or equipment; and

(4) the recipient resides in a setting that is suitable for telemonitoring and not in a setting that has health care staff on site.

(b) For purposes of this subdivision, "telemonitoring services" means the remote monitoring of data related to a recipient's vital signs or biometric data by a monitoring device or equipment that transmits the data electronically to a provider for analysis. The assessment and monitoring of the health data transmitted by telemonitoring must be performed by one of the following licensed health care professionals: physician, podiatrist, registered nurse, advanced practice registered nurse, physician assistant, respiratory therapist, or licensed professional working under the supervision of a medical director.

Subd. 4. **Outpatient and physician-directed clinic services.** Medical assistance covers outpatient hospital or physician-directed clinic services. All services provided by physician-directed clinic staff must be under the direction 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.

[See Note.]

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 must be certified as a mental health clinic under section 245I.20.

(b) In addition to the policies and procedures required by section 245I.03, the provider must establish, enforce, and maintain the policies and procedures for oversight of clinical services by a doctoral-level psychologist or a board-certified or board-eligible psychiatrist. These policies and procedures must be developed with the involvement of a doctoral-level psychologist and a board-certified or board-eligible psychiatrist, and must include:

(1) requirements for when to seek clinical consultation with a doctoral-level psychologist or a board-certified or board-eligible psychiatrist;

(2) requirements for the involvement of a doctoral-level psychologist or a board-certified or board-eligible psychiatrist in the direction of clinical services; and

(3) involvement of a doctoral-level psychologist or a board-certified or board-eligible psychiatrist in quality improvement initiatives and review as part of a multidisciplinary care team.

(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 intervention psychotherapy services, 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, multiple family group psychotherapy, 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 mentally ill.

(f) The provider must be capable of providing the services specified in paragraph (e) to individuals who are dually diagnosed with mental illness and substance use disorder, and to individuals who are dually diagnosed with mental illness 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.

(k) The commissioner may require the provider to annually attest that the provider meets the requirements in this subdivision using a form that the commissioner provides.

Subd. 5a. MS 2006 [Repealed, 2007 c 147 art 5 s 41]

Subd. 5b. MS 2006 [Repealed, 2007 c 147 art 5 s 41]

Subd. 5c. MS 2006 [Repealed, 2007 c 147 art 5 s 41]

Subd. 5d. MS 2006 [Repealed, 2007 c 147 art 5 s 41]

Subd. 5e. MS 2006 [Repealed, 2007 c 147 art 5 s 41]

Subd. 5f. MS 2006 [Repealed, 2007 c 147 art 5 s 41]

Subd. 5g. MS 2006 [Repealed, 2007 c 147 art 5 s 41]

Subd. 5h. MS 2006 [Repealed, 2007 c 147 art 5 s 41]

Subd. 5i. MS 2006 [Repealed, 2007 c 147 art 5 s 41]

Subd. 5j. MS 2006 [Repealed, 2007 c 147 art 5 s 41]

Subd. 5k. MS 2006 [Repealed, 2007 c 147 art 5 s 41]

Subd. 5l. MS 2020 [Repealed, 2021 c 30 art 17 s 113]

Subd. 5m. **Certified community behavioral health clinic services.** (a) Medical assistance covers services provided by a not-for-profit certified community behavioral health clinic (CCBHC) that meets the requirements of section 245I.17.

(b) The commissioner must reimburse CCBHCs on a per-day basis for each day that an eligible service is delivered using the CCBHC daily bundled rate system for medical assistance payments as described in paragraph (c). The commissioner must include a quality incentive payment in the CCBHC daily bundled rate system as described in paragraph (e). There is no county share for medical assistance services when reimbursed through the CCBHC daily bundled rate system.

(c) The commissioner must ensure that the CCBHC daily bundled rate system for CCBHC payments under medical assistance meets the following requirements:

(1) the CCBHC daily bundled rate must be a provider-specific rate calculated for each CCBHC, based on the daily cost of providing CCBHC services and the total annual allowable CCBHC costs divided by the total annual number of CCBHC visits. For calculating the payment rate, total annual visits include visits covered by medical assistance and visits not covered by medical assistance. Allowable costs include but are not limited to the salaries and benefits of medical assistance providers; the cost of CCBHC services provided under section 245I.17, subdivision 4; and other costs such as insurance or supplies needed to provide CCBHC services;

(2) payment must be limited to one payment per day per medical assistance enrollee when an eligible CCBHC service is provided. A CCBHC visit is eligible for reimbursement if at least one of the CCBHC services listed under section 245I.17, subdivision 4, is furnished to a medical assistance enrollee by a health care practitioner or licensed agency employed by or under contract with a CCBHC;

(3) initial CCBHC daily bundled rates for newly licensed CCBHCs under section 245I.17 must be established by the commissioner using a provider-specific rate based on the newly licensed CCBHC's audited historical cost report data adjusted for the expected cost of delivering CCBHC services. Estimates are subject to review by the commissioner and must include the expected cost of providing the full scope of CCBHC services and the expected number of visits for the rate period;

(4) the commissioner must rebase CCBHC rates once every two years following the last rebasing and no less than 12 months following an initial rate or a rate change due to a change in the scope of services;

(5) the commissioner must provide for a 60-day appeals process after notice of the results of the rebasing;

(6) an entity that receives a CCBHC daily bundled rate that overlaps with another federal Medicaid rate is not eligible for the CCBHC rate methodology;

(7) payments for CCBHC services to individuals enrolled in managed care must be coordinated with the state's phase-out of CCBHC wrap payments. The commissioner must complete the phase-out of CCBHC wrap payments within 60 days of the implementation of the CCBHC daily bundled rate system in the Medicaid Management Information System (MMIS), for CCBHCs reimbursed under this chapter, with a final settlement of payments due made payable to CCBHCs no later than 18 months thereafter;

(8) the CCBHC daily bundled rate for each CCBHC must be updated by trending each provider-specific rate by the Medicare Economic Index for primary care services. This update must occur each year in between rebasing periods determined by the commissioner in accordance with clause (4). CCBHCs must provide data on costs and visits to the state annually using the CCBHC cost report established by the commissioner; and

(9) a CCBHC may request a rate adjustment for changes in the CCBHC's scope of services when such changes are expected to result in an adjustment to the CCBHC payment rate by 2.5 percent or more. The CCBHC must provide the commissioner with information regarding the changes in the scope of services, including the estimated cost of providing the new or modified services and any projected increase or decrease in the number of visits resulting from the change. Estimated costs are subject to review by the commissioner. Rate adjustments for changes in scope must occur no more than once per year in between rebasing periods per CCBHC and are effective on the date of the annual CCBHC rate update.

(d) Managed care plans and county-based purchasing plans must reimburse CCBHC providers at the CCBHC daily bundled rate. The commissioner must monitor the effect of this requirement on the rate of access to the services delivered by CCBHC providers. If, for any contract year, federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this provision. This paragraph expires if federal approval is not received for this paragraph at any time.

(e) The commissioner must implement a quality incentive payment program for CCBHCs that meets the following requirements:

(1) a CCBHC must receive a quality incentive payment upon meeting specific numeric thresholds for performance metrics established by the commissioner, in addition to payments for which the CCBHC is eligible under the CCBHC daily bundled rate system described in paragraph (c);

(2) a CCBHC must be licensed and enrolled as a CCBHC for the entire measurement year to be eligible for incentive payments;

(3) each CCBHC must receive written notice of the criteria that must be met in order to receive quality incentive payments at least 90 days prior to the measurement year; and

(4) a CCBHC must provide the commissioner with data needed to determine incentive payment eligibility within six months following the measurement year. The commissioner must notify CCBHC providers of their performance on the required measures and the incentive payment amount within 12 months following the measurement year.

(f) All claims to managed care plans for CCBHC services as provided under this section must be submitted directly to, and paid by, the commissioner on the dates specified no later than January 1 of the following calendar year, if:

(1) one or more managed care plans does not comply with the federal requirement for payment of clean claims to CCBHCs, as defined in Code of Federal Regulations, title 42, section 447.45(b), and the managed care plan does not resolve the payment issue within 30 days of noncompliance; and

(2) the total amount of clean claims not paid in accordance with federal requirements by one or more managed care plans is 50 percent of, or greater than, the total CCBHC claims eligible for payment by managed care plans.

If the conditions in this paragraph are met between January 1 and June 30 of a calendar year, claims must be submitted to and paid by the commissioner beginning on January 1 of the following year. If the conditions in this paragraph are met between July 1 and December 31 of a calendar year, claims must be submitted to and paid by the commissioner beginning on July 1 of the following year.

(g) Peer services provided by a CCBHC licensed under section 245I.17 are a covered service under medical assistance when a licensed mental health professional or alcohol and drug counselor determines that peer services are medically necessary. Eligibility under this subdivision for peer services provided by a CCBHC supersede eligibility standards under sections 256B.0615, 256B.0616, and 245G.07, subdivision 2a, paragraph (b), clause (2).

[See Note.]

Subd. 5n. **Conversion therapy.** Medical assistance does not cover conversion therapy as defined in section 214.078, subdivision 1.

Subd. 6. MS 1990 [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 or in the community where normal life activities take the recipient. 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, 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.

(c) Payment for physical therapy and related services is limited to 14 visits per year unless prior authorization of a greater number of visits is obtained. This paragraph expires upon the effective date of paragraph (d).

(d) Effective January 1, 2027, or upon federal approval, whichever is later, payment for physical therapy and related services is limited to the following number of visits per year unless prior authorization of a greater number of visits is obtained:

(1) for children following an inpatient or outpatient hospital-based surgery, 30 visits; and

(2) for all other recipients, 14 visits.

[See Note.]

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.

(c) Payment for occupational therapy and related services is limited to 24 visits per year unless prior authorization of a greater number of visits is obtained.

[See Note.]

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 individuals under the age of 21. Coverage for individuals under the age of 21 is limited to one annual evaluation and 24 visits per year unless prior authorization of a greater number of visits is obtained.

[See Note.]

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 medically necessary dental services.

(b) The following guidelines apply to dental services:

(1) posterior fillings are paid at the amalgam rate;

(2) application of sealants are covered once every five years per permanent molar; and

(3) application of fluoride varnish is covered once every six months.

(c) In addition to the services specified in paragraph (a), medical assistance covers the following services:

(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.

(d) The commissioner shall not require prior authorization for the services included in paragraph (c), clauses (1) to (3), and shall prohibit managed care and county-based purchasing plans from requiring prior authorization for the services included in paragraph (c), 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. 9b. **Dental services provided by faculty members and resident dentists at a dental school.** (a) A dentist who is not enrolled as a medical assistance provider, is a faculty or adjunct member at the University of Minnesota or a resident dentist licensed under section 150A.06, subdivision 1b, and is providing dental services at a dental clinic owned or operated by the University of Minnesota, may be enrolled as a medical assistance provider if the provider completes and submits to the commissioner an agreement form developed by the commissioner. The agreement must specify that the faculty or adjunct member or resident dentist:

(1) will not receive payment for the services provided to medical assistance or MinnesotaCare enrollees performed at the dental clinics owned or operated by the University of Minnesota;

(2) will not be listed in the medical assistance or MinnesotaCare provider directory; and

(3) is not required to serve medical assistance and MinnesotaCare enrollees when providing nonvolunteer services in a private practice.

(b) A dentist or resident dentist enrolled under this subdivision as a fee-for-service provider shall not otherwise be enrolled in or receive payments from medical assistance or MinnesotaCare as a fee-for-service provider.

Subd. 10. **Laboratory, x-ray, and opioid testing services.** (a) Medical assistance covers laboratory and x-ray services.

(b) Medical assistance covers screening and urinalysis tests for opioids without lifetime or annual limits.

(c) Medical assistance covers laboratory tests ordered and performed by a licensed pharmacist, according to the requirements of section 151.01, subdivision 27, clause (3), at no less than the rate for which the same services are covered when provided by any other licensed practitioner.

[See Note.]

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.** Medical assistance covers eyeglasses 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, a physician assistant, or an advanced practice registered nurse 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 or as provided in paragraph (h) or the drug appears on the 90-day supply list published by the commissioner. The 90-day supply list shall be published by the commissioner on the department's website. The commissioner may add to, delete from, and otherwise modify the 90-day supply list after providing public notice and the opportunity for a 15-day public comment period. The 90-day supply list may include cost-effective generic drugs and shall not include controlled substances.

(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 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.

(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.

(g) Notwithstanding paragraph (a), medical assistance covers self-administered hormonal contraceptives prescribed and dispensed by a licensed pharmacist in accordance with section 151.37, subdivision 14; nicotine

replacement medications prescribed and dispensed by a licensed pharmacist in accordance with section 151.37, subdivision 15; and opiate antagonists used for the treatment of an acute opiate overdose prescribed and dispensed by a licensed pharmacist in accordance with section 151.37, subdivision 16.

(h) Medical assistance coverage for a prescription contraceptive must provide a 12-month supply for any prescription contraceptive if a 12-month supply is prescribed by the prescribing health care provider. The prescribing health care provider must determine the appropriate duration for which to prescribe the prescription contraceptives, up to 12 months. For purposes of this paragraph, "prescription contraceptive" means any drug or device that requires a prescription and is approved by the Food and Drug Administration to prevent pregnancy. Prescription contraceptive does not include an emergency contraceptive drug approved to prevent pregnancy when administered after sexual contact. For purposes of this paragraph, "health plan" has the meaning provided in section 62Q.01, subdivision 3.

(i) Notwithstanding a removal of a drug from the drug formulary under subdivision 13d, except as provided in paragraphs (j) and (k), medical assistance covers a drug, with respect to an enrollee who was previously prescribed the drug during the calendar year when the drug was on the formulary, at the same level until January 1 of the calendar year following the year in which the commissioner removed the drug from the formulary.

(j) Paragraph (i) does not apply if the commissioner changes the drug formulary:

(1) for a drug that has been deemed unsafe by the United States Food and Drug Administration (FDA);

(2) for a drug that has been withdrawn by the FDA or the drug manufacturer; or

(3) when an independent source of research, clinical guidelines, or evidence-based standards has issued drug-specific warnings or recommended changes with respect to a drug's use for reasons related to previously unknown and imminent patient harm.

(k) Paragraph (i) does not apply when the commissioner removes a brand name drug from the formulary if the commissioner adds to the formulary a generic or multisource brand name drug rated as therapeutically equivalent according to the FDA Orange Book, or a biologic drug rated as interchangeable according to the FDA Purple Book, at the same or lower cost to the enrollee.

[See Note.]

Subd. 13a. MS 2006 [Repealed, 2007 c 133 art 2 s 13]

Subd. 13b. MS 1996 [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 at least five licensed physicians actively engaged in the practice of medicine in Minnesota, one of whom is an actively practicing psychiatrist, one of whom specializes in the diagnosis and treatment of rare diseases, one of whom specializes in pediatrics, and one of whom actively treats persons with disabilities; at least three licensed pharmacists actively engaged in the practice of pharmacy in Minnesota, one of whom practices outside the metropolitan counties listed in section 473.121, subdivision 4, one of whom practices in the metropolitan counties listed in section 473.121, subdivision 4, and one of whom is a practicing hospital pharmacist; at least two consumer representatives, all of whom must have a personal or professional connection to medical assistance; and one representative designated by the Minnesota Rare Disease Advisory Council established under section 256.4835; 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 or have a personal interest in a pharmaceutical company, pharmacy benefits manager, health plan company, or their affiliate organizations, but the committee shall be staffed by an employee of the department who shall serve as an ex officio, nonvoting member of the committee. For the purposes of this subdivision, "personal interest" means that a person owns at least five percent of the voting interest or equity interest in the entity, the equity interest owned by a person represents at least five percent of that person's net worth, or more than five percent of a person's gross income for the preceding year was derived from the entity. A committee member must notify the committee of any potential conflict of interest and recuse themselves from any communications, discussion, or vote on any matter where a conflict of interest exists. A conflict of interest alone, without a personal interest, does not preclude an applicant from serving as a member of the Formulary Committee. Members may be removed from the committee for cause after a recommendation for removal by a majority of the committee membership. For the purposes of this subdivision, "cause" does not include offering a differing or dissenting clinical opinion on a drug or drug class. 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 twice by the commissioner. The committee members shall vote on a chair and vice chair from among their membership. The chair shall preside over all committee meetings, and the vice chair shall preside over the meetings if the chair is not present. The Formulary Committee shall meet at least three times 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, 2029. The Formulary Committee is subject to the Open Meeting Law under chapter 13D. For purposes of establishing a quorum to transact business, vacant committee member positions do not count in the calculation as long as at least 60 percent of the committee member positions are filled.

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 when used for the treatment of impotence or erectile dysfunction;

(4) drugs or active pharmaceutical ingredients for which medical value has not been established;

(5) 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

(6) medical cannabis flower as defined in section 342.01, subdivision 54, or medical cannabinoid products as defined in section 342.01, subdivision 52.

(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.

(d) Within ten calendar days of any commissioner determination to change the drug formulary, the commissioner must provide written notice to all enrollees, prescribers, and pharmacists affected by the change. The notice must include a description of the change, the reason for the change, and the date the change will become effective.

(e) By January 15, 2026, and annually thereafter, the commissioner of human services must provide a report with data and information related to the effects on enrollees of drug formulary changes made in the prior calendar year to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance. The report must include but is not limited to data and information on:

(1) the number of times the formulary was changed;

(2) the reasons for the formulary changes and how frequently the formulary was changed for each reason;

(3) the drugs that were removed from the formulary;

(4) for each drug that was removed from the formulary, the number of enrollees who were prescribed that drug when it was removed;

(5) for each drug that was removed from the formulary, whether a therapeutically equivalent drug was added;

(6) the drugs that were added to the formulary;

(7) the fiscal impacts to the Department of Human Services resulting from the changes to the formulary; and

(8) enrollee populations or medical conditions disproportionately affected by the formulary changes.

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the ingredient costs of the drugs plus the professional dispensing fee; or the usual and customary price charged to the public. The usual and customary price means the lowest price charged by the provider to a patient who pays for the prescription by cash, check, or charge account and includes prices the pharmacy charges to a patient enrolled in a prescription savings club or prescription discount club administered by the pharmacy or pharmacy chain, unless the prescription savings club or prescription discount club is one in which an individual pays a recurring monthly access fee for unlimited access to a defined list of drugs for which the pharmacy does not bill the member or a payer on a per-standard-transaction basis. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any third-party 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 professional dispensing fee shall be $11.55 for prescriptions filled with legend drugs meeting the definition of "covered outpatient drugs" according to United States Code, title 42, section 1396r-8(k)(2). The dispensing fee for intravenous solutions that must be compounded by the pharmacist shall be $11.55 per claim. The professional dispensing fee for prescriptions filled with over-the-counter drugs meeting the definition of covered outpatient drugs shall be $11.55 for dispensed quantities equal to or greater than the number of units contained in the manufacturer's original package. The professional dispensing fee shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses a quantity less than the number of units contained in the manufacturer's original package. The pharmacy dispensing fee for prescribed over-the-counter drugs

not meeting the definition of covered outpatient drugs shall be $3.65 for quantities equal to or greater than the number of units contained in the manufacturer's original package and shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses a quantity less than the number of units contained in the manufacturer's original package. The ingredient cost for a drug is either: (1) the lower of the National Average Drug Acquisition Cost (NADAC) or the Minnesota actual acquisition cost (MNAAC) under paragraph (i); (2) the maximum allowable cost, if a drug ingredient cost is unreported in the NADAC and the MNAAC; or (3) the wholesale acquisition cost minus two percent, if a drug ingredient cost is unreported in the NADAC and the MNAAC and a maximum allowable cost is unavailable. The ingredient cost of a drug for a provider participating in the federal 340B Drug Pricing Program is either: (1) the lowest of the 340B ceiling price established by the Health Resources and Services Administration, the NADAC, or the MNAAC; (2) the maximum allowable cost, if the 340B ceiling price is unknown and the drug ingredient cost is unreported in the NADAC and the MNAAC; or (3) the wholesale acquisition cost minus two percent, if the 340B ceiling price is unknown, the drug ingredient cost is unreported in the NADAC and the MNAAC, and the maximum allowable cost is unavailable. 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 drug may be set by the commissioner and it shall be comparable to the actual acquisition cost of the drug product. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) Pharmacies dispensing prescriptions to residents of long-term care facilities using an automated drug distribution system meeting the requirements of section 151.58, or a packaging system meeting the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ retrospective billing for prescription drugs dispensed to long-term care facility residents. A retrospectively billing pharmacy must submit a claim only for the quantity of medication used by the enrolled recipient during the defined billing period. A retrospectively billing pharmacy must use a billing period not less than one calendar month or 30 days.

(c) A pharmacy provider using packaging that meets the standards set forth in Minnesota Rules, part 6800.2700, is required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse, unless the pharmacy is using retrospective billing. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply.

(d) If a pharmacy dispenses a multisource drug, the ingredient cost is either: (1) the lower of the NADAC or the MNAAC of the generic product; (2) the maximum allowable cost, if the generic product ingredient cost is unreported in the NADAC and the MNAAC; or (3) the wholesale acquisition cost minus two percent of the generic product established by the commissioner, if the generic drug ingredient cost is unreported in the NADAC and the MNAAC and a maximum allowable cost is unavailable, 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. If prior authorization is granted, the ingredient cost is either: (1) the lower of the NADAC or the MNAAC of the brand name product; (2) the maximum allowable cost, if the drug ingredient cost is unreported in the NADAC and MNAAC; or (3) the wholesale acquisition cost minus two percent, if the drug ingredient cost is unreported in the NADAC and the MNAAC and the maximum allowable cost is unavailable. A generic product includes a generic drug, an authorized generic drug, and a biosimilar biological product as defined in Code of Federal Regulations, title 42, section 423.4. A brand name product includes a brand name drug, a brand name

biological product, and an unbranded biological product as defined in Code of Federal Regulations, title 42, section 423.4.

(e) The basis for determining the amount of payment for drugs administered in an outpatient setting is the lowest 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 MNAAC, or the maximum allowable cost set by the commissioner. If the average sales price, the MNAAC, and the maximum allowable cost are unavailable, the amount of payment must be the lower of the usual and customary cost submitted by the provider or the wholesale acquisition cost. The commissioner shall discount the payment rate for drugs obtained through the federal 340B Drug Pricing Program by 28.6 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.

(f) Home infusion therapy services provided by home infusion therapy pharmacies must be paid at rates according to subdivision 8d.

(g) The commissioner shall contract with a vendor to conduct a cost of dispensing survey for all pharmacies that are physically located in the state of Minnesota that dispense outpatient drugs under medical assistance. The commissioner shall ensure that the vendor has prior experience in conducting cost of dispensing surveys. Each pharmacy enrolled with the department to dispense outpatient prescription drugs to fee-for-service members must respond to the cost of dispensing survey. The commissioner may sanction a pharmacy under section 256B.064 for failure to respond. The commissioner shall require the vendor to measure a single statewide cost of dispensing for specialty prescription drugs and a single statewide cost of dispensing for nonspecialty prescription drugs for all responding pharmacies to measure the mean, mean weighted by total prescription volume, mean weighted by medical assistance prescription volume, median, median weighted by total prescription volume, and median weighted by total medical assistance prescription volume. The commissioner shall post a copy of the final cost of dispensing survey report on the department's website. The initial survey must be completed no later than January 1, 2021, and repeated every three years. The commissioner shall provide a summary of the results of each cost of dispensing survey and provide recommendations for any changes to the dispensing fee to the chairs and ranking minority members of the legislative committees with jurisdiction over medical assistance pharmacy reimbursement. Notwithstanding section 256.01, subdivision 42, this paragraph does not expire.

(h) The commissioner shall increase the ingredient cost reimbursement calculated in paragraphs (a), (d), and (e) by the amount of the wholesale drug distributor tax under section 295.52 for prescription and nonprescription drugs subject to the tax.

(i) The commissioner shall contract with a vendor to create the MNAAC through a periodic survey of enrolled pharmacy providers. The initial MNAAC must be completed by January 1, 2027. Each pharmacy enrolled with the department to dispense outpatient prescription drugs must respond to the periodic surveys. The commissioner may sanction a pharmacy under section 256B.064 for failure to respond. The commissioner must exclude drug purchases under the federal 340B Drug Pricing Program and Federal Supply Schedule invoices from any measure and calculation of the MNAAC. The current MNAAC rates must be publicly available on the department's or vendor's website. The commissioner must require that the MNAAC is measured and calculated at least quarterly. The commissioner must ensure that the vendor has an appeal process available to providers for the time between the measurement and calculation of the periodically updated MNAAC rates if price fluctuations result in a MNAAC that is lower than the price at which enrolled providers can purchase a drug. Establishment of the MNAAC and survey reporting requirements are not

subject to the requirements of the Administrative Procedure Act. Data provided by pharmacies for the measurement and calculation of the MNAAC are nonpublic data as defined in section 13.02, subdivision 9.

[See Note.]

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 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 must not be required for liquid methadone if only one version of liquid methadone is available. If more than one version of liquid methadone is available, the commissioner shall ensure that at least one version of liquid methadone is available without prior authorization.

(e) Prior authorization may be required for an oral liquid form of a drug, except as described in paragraph (d). A prior authorization request under this paragraph must be automatically approved within 24 hours if the drug is being prescribed for a Food and Drug Administration-approved condition for a patient who utilizes an enteral tube for feedings or medication administration, even if the patient has current or prior claims for pills for that condition. If more than one version of the oral liquid form of a drug is available, the commissioner may select the version that is able to be approved for a Food and Drug Administration-approved

condition for a patient who utilizes an enteral tube for feedings or medication administration. This paragraph applies to any multistate preferred drug list or supplemental drug rebate program established or administered by the commissioner. The commissioner shall design and implement a streamlined prior authorization form for patients who utilize an enteral tube for feedings or medication administration and are prescribed an oral liquid form of a drug. 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.

(g) Prior authorization under this subdivision shall comply with section 62Q.184.

(h) Any step therapy protocol requirements established by the commissioner must comply with section 62Q.1841.

(i) Notwithstanding any law to the contrary, prior authorization or step therapy shall not be required or utilized for any class of drugs that is approved by the United States Food and Drug Administration for the treatment or prevention of HIV and AIDS.

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 terms of the contract with the vendor must be publicly disclosed on the website of the Department of Human Services. 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 website. The commissioner shall implement and maintain an accurate archive of previous versions of the preferred drug list, and make this archive available to the public on the website of the Department of Human Services beginning January 1, 2024.

(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, providing public notice and the opportunity for public comment, and complying with the requirements of paragraph (f).

(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, the following terms have the meanings given:

(1) "appropriate medical specialist" means a medical professional who prescribes the relevant class of drug as part of their practice; and

(2) "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.

(f) Before the commissioner may delete a drug from the preferred drug list or modify the inclusion of a drug on the preferred drug list, the commissioner shall consider any implications that the deletion or modification may have on state public health policies or initiatives and any impact that the deletion or modification may have on increasing health disparities in the state. Prior to deleting a drug or modifying the inclusion of a drug, the commissioner shall also conduct a public hearing. The commissioner shall provide adequate notice to the public and the commissioner of health prior to the hearing that specifies the drug that the commissioner is proposing to delete or modify, and shall disclose any public medical or clinical analysis that the commissioner has relied on in proposing the deletion or modification and evidence that the commissioner has evaluated the impact of the proposed deletion or modification on public health and health disparities. Notwithstanding section 331A.05, a public notice of a Formulary Committee meeting must be published at least 30 days in advance of the meeting. The list of drugs to be discussed at the meeting must be announced at least 30 days before the meeting and must include the name and class of drug, the proposed action, and the proposed prior authorization requirements, if applicable.

Subd. 13h. **Medication therapy management services.** (a) Medical assistance covers medication therapy management services for a recipient taking prescriptions to treat or prevent one or more chronic medical conditions. For purposes of this subdivision, "medication therapy 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, which may include prescribing medications or products in accordance with section 151.37, subdivision 14, 15, or 16;

(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; and

(3) 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 providers. The commissioner may also establish limits on the number of reimbursable consultations per recipient.

(d) Medication therapy management services may be provided via telehealth as defined in subdivision 3b and may be delivered into a patient's residence. 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).

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:

(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.

(c) For purposes of this subdivision, a collaborative psychiatric consultation must meet the criteria described in section 245.4862, subdivision 4.

Subd. 13k. **Value-based purchasing arrangements.** (a) The commissioner may enter into a value-based purchasing arrangement under medical assistance or MinnesotaCare, by written arrangement with a drug manufacturer based on agreed-upon metrics. The commissioner may contract with a vendor to implement and administer the value-based purchasing arrangement. A value-based purchasing arrangement may include but is not limited to rebates, discounts, price reductions, risk sharing, reimbursements, guarantees, shared

savings payments, withholds, or bonuses. A value-based purchasing arrangement must provide at least the same value or discount in the aggregate as would claiming the mandatory federal drug rebate under the Federal Social Security Act, section 1927.

(b) Nothing in this section shall be interpreted as requiring a drug manufacturer or the commissioner to enter into an arrangement as described in paragraph (a).

(c) Nothing in this section shall be interpreted as altering or modifying medical assistance coverage requirements under the federal Social Security Act, section 1927.

(d) If the commissioner determines that a state plan amendment is necessary before implementing a value-based purchasing arrangement, the commissioner shall request the amendment and may delay implementing this provision until the amendment is approved.

(e) The commissioner may provide separate reimbursement to hospitals for drugs provided in the inpatient hospital setting as part of a value-based purchasing arrangement. This payment must be separate from the diagnostic related group reimbursement for the inpatient admission or discharge associated with a stay during which the patient received a drug under this section. For payments made under this section, the hospital must not be reimbursed for the drug under the payment methodology in section 256.969. The commissioner shall establish the separate reimbursement rate for drugs provided under this section based on the methodology used for drugs administered in an outpatient setting under section 256B.0625, subdivision 13e, paragraph (e).

[See Note.]

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 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 abortions and abortion-related services, including preabortion services and follow-up services.

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.

(b) 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. This paragraph expires upon implementation of the administrator under subdivision 18i.

(c) 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, nonemergency medical transportation company, 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 that meet the requirements of this subdivision;

(4) public transportation, within the meaning of "public transportation" as defined in section 174.22, subdivision 7; or

(5) not-for-hire vehicles, including volunteer drivers, as defined in section 65B.472, subdivision 1, paragraph (p).

(d) 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 all drivers must be individually enrolled with the commissioner and reported on the claim as the individual who provided the service. 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. This paragraph expires upon the effective date of paragraph (e).

(e) Effective January 1, 2027, or upon federal approval, whichever is later, 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 all drivers must be individually enrolled with the commissioner and reported on the claim as the individual who provided the service. All nonemergency medical transportation providers must bill for nonemergency medical transportation services in accordance with Minnesota health care programs criteria and comply with the requirements under section 256B.073. Publicly operated transit systems, volunteers, and not-for-hire vehicles are exempt from the requirements in this paragraph.

(f) An organization may be terminated, denied, or suspended from enrollment if:

(1) the provider has not initiated background studies on the individuals specified in section 174.30, subdivision 10, paragraph (a), clauses (1) to (3); or

(2) the provider has initiated background studies on the individuals specified in section 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

(i) the commissioner has sent the provider a notice that the individual has been disqualified under section 245C.14; and

(ii) the individual has not received a disqualification set-aside specific to the special transportation services provider under sections 245C.22 and 245C.23.

(g) The administrative agency of nonemergency medical transportation must:

(1) adhere to the policies defined by the commissioner;

(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. This paragraph expires upon implementation of the administrator under subdivision 18i.

(h) Effective upon implementation of the administrator under subdivision 18i, the administrative agency of nonemergency medical transportation must:

(1) adhere to the policies defined by the commissioner;

(2) pay nonemergency medical transportation providers for services provided to Minnesota health care program beneficiaries to obtain covered medical services; and

(3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled trips, and number of trips by mode.

(i) 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 of transportation under paragraph (o), clauses (4), (5), (6), and (7). This paragraph expires upon implementation of the administrator under subdivision 18i.

(j) The commissioner may use an order by the recipient's attending physician, advanced practice registered nurse, physician assistant, 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, child seats, or stretchers in the vehicle.

(k) 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. This paragraph expires upon implementation of the administrator under subdivision 18i.

(l) Effective upon implementation of the administrator under subdivision 18i, 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 administrator.

(m) 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 maintain trip logs, which include pickup and drop-off times, signed by the medical provider or client, whichever is deemed most appropriate, attesting to mileage traveled to obtain covered medical services. Clients requesting client mileage reimbursement must sign the trip log attesting mileage traveled to obtain covered medical services.

(n) The administrative agency shall use the level of service process established by the commissioner 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.

(o) The covered modes of transportation are:

(1) client reimbursement, which includes client mileage reimbursement provided to clients who have their own transportation, or to family or an acquaintance 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 public transit 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 provided to a client who has received a prescreening that has deemed other forms of transportation inappropriate and who requires a provider: (i) with 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; and (ii) who is 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.

(p) The local agency shall be the single administrative agency and shall administer and reimburse for modes defined in paragraph (o) according to paragraphs (s) to (u) when the commissioner has developed, made available, and funded the web-based single administrative structure, assessment tool, and level of need assessment under subdivision 18e. The local agency's financial obligation is limited to funds provided by the state or federal government. This paragraph expires upon implementation of the administrator under subdivision 18i.

(q) The commissioner shall:

(1) 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.

(r) 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 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. This paragraph expires upon implementation of the administrator under subdivision 18i.

(s) Payments for nonemergency medical transportation must be paid based on the client's assessed mode under paragraph (n), not the type of vehicle used to provide the service. The medical assistance reimbursement rates for nonemergency medical transportation services that are payable by or on behalf of the commissioner for nonemergency medical transportation services are:

(1) $0.22 per mile for client reimbursement;

(2) up to 100 percent of the Internal Revenue Service business deduction rate for volunteer transport;

(3) equivalent to the standard fare for unassisted transport when provided by public transit, and $12.10 for the base rate and $1.43 per mile when provided by a nonemergency medical transportation provider;

(4) $14.30 for the base rate and $1.43 per mile for assisted transport;

(5) $19.80 for the base rate and $1.70 per mile for lift-equipped/ramp transport;

(6) $75 for the base rate and $2.40 per mile for protected transport; and

(7) $60 for the base rate and $2.40 per mile for stretcher transport, and $9 per trip for an additional attendant if deemed medically necessary. This paragraph expires upon implementation of the administrator under subdivision 18i.

(t) Effective upon implementation of the administrator under subdivision 18i, for prepaid medical assistance, payments for nonemergency medical transportation must be paid based on the client's assessed mode under paragraph (n), not the type of vehicle used to provide the service.

(u) The base rate for nonemergency medical transportation services in areas defined under RUCA to be super rural is equal to 111.3 percent of the respective base rate in paragraph (s), clauses (1) to (7). The mileage rate for nonemergency medical transportation services in areas defined under RUCA to be rural or super rural areas is:

(1) for a trip equal to 17 miles or less, equal to 125 percent of the respective mileage rate in paragraph (s), clauses (1) to (7); and

(2) for a trip between 18 and 50 miles, equal to 112.5 percent of the respective mileage rate in paragraph (s), clauses (1) to (7). This paragraph expires upon implementation of the administrator under subdivision 18i.

(v) For purposes of reimbursement rates for nonemergency medical transportation services under paragraphs (s) to (u), the zip code of the recipient's place of residence shall determine whether the urban, rural, or super rural reimbursement rate applies. This paragraph expires upon implementation of the administrator under subdivision 18i.

(w) The commissioner, when determining reimbursement rates for nonemergency medical transportation, shall exempt all modes of transportation listed under paragraph (o) from Minnesota Rules, part 9505.0445, item R, subitem (2).

(x) Effective for the first day of each calendar quarter in which the price of gasoline as posted publicly by the United States Energy Information Administration exceeds $3.00 per gallon, the commissioner shall adjust the rate paid per mile in paragraph (s) by one percent up or down for every increase or decrease of ten cents for the price of gasoline. The increase or decrease must be calculated using a base gasoline price of $3.00. The percentage increase or decrease must be calculated using the average of the most recently available price of all grades of gasoline for Minnesota as posted publicly by the United States Energy Information Administration. This paragraph expires upon implementation of the administrator under subdivision 18i.

[See Note.]

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 July 1, 2016, medical assistance payment rates for ambulance services identified in this paragraph are increased by five percent. Capitation payments made to managed care plans and county-based purchasing plans for ambulance services provided on or after January 1, 2017, shall be increased to reflect this rate increase. The increased rate described in this paragraph applies to ambulance service providers whose base of operations as defined in section 144E.10 is located:

(1) outside the metropolitan counties listed in section 473.121, subdivision 4, and outside the cities of Duluth, Mankato, Moorhead, St. Cloud, and Rochester; or

(2) within a municipality with a population of less than 1,000.

(c) Effective for the first day of each calendar quarter in which the price of gasoline as posted publicly by the United States Energy Information Administration exceeds $3.00 per gallon, the commissioner shall adjust the rate paid per mile in paragraph (a) by one percent up or down for every increase or decrease of ten cents for the price of gasoline. The increase or decrease must be calculated using a base gasoline price of $3.00. The percentage increase or decrease must be calculated using the average of the most recently available price of all grades of gasoline for Minnesota as posted publicly by the United States Energy Information Administration.

(d) Managed care plans and county-based purchasing plans must provide a fuel adjustment for ambulance services rates when fuel exceeds $3 per gallon. If, for any contract year, federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this paragraph. This paragraph expires if federal approval is not received for this paragraph at any time.

Subd. 17b. **Documentation required.** (a) As a condition for payment, nonemergency medical transportation providers must document each occurrence of a service provided to a recipient according to this subdivision. Providers must maintain records sufficient to distinguish individual trips with specific vehicles and drivers. The documentation may be collected and maintained using electronic systems or software or in paper form but must be made available and produced upon request. Program funds paid for transportation that is not documented according to this subdivision may be subject to recovery by the commissioner pursuant to section 256B.064.

(b) A nonemergency medical transportation provider must compile transportation trip records that are written in English and legible according to the standard of a reasonable person and that include each of the following elements:

(1) the recipient's name;

(2) the date or dates the service is provided, if different than the date the entry was made;

(3) either the printed name of the driver sufficient to distinguish the driver of service or the driver's provider number;

(4) the date and the signature of the driver attesting that the record accurately represents the services provided and the actual miles driven, and acknowledging that misreporting information that results in ineligible or excessive payments may result in civil or criminal action;

(5) the date and the signature of the recipient or authorized party attesting that transportation services were provided as indicated on the transportation trip record, or the signature of the medical services provider certifying that the recipient was transported to the medical services provider destination. In the event that both the medical services provider and the recipient or authorized party refuse or are unable to provide signatures, the driver must document on the transportation trip record that signatures were requested and not provided;

(6) the address, or the description if the address is not available, of both the origin and destination, and the mileage for the most direct route from the origin to the destination;

(7) the name or number of the mode of transportation in which the service is provided;

(8) the license plate number of the vehicle used to transport the recipient;

(9) the time of the recipient pickup;

(10) the time of the recipient drop-off;

(11) the odometer reading of the vehicle used to transport the recipient taken at the time of pickup;

(12) the odometer reading of the vehicle used to transport the recipient taken at the time of drop-off;

(13) the name of the extra attendant when an extra attendant is used to provide special transportation service; and

(14) the documentation indicating the method that was used to determine the most direct route.

(c) In determining whether the commissioner will seek recovery, the documentation requirements in this section apply retroactively to audit findings beginning January 1, 2020, and to all audit findings thereafter.

(d) Effective January 1, 2027, or upon federal approval, whichever is later, records that comply with section 256B.073 may be used to meet the requirements under this subdivision if all required elements are included in the record.

Subd. 17c. **Nursing facility transports.** A Minnesota health care program enrollee residing in, or being discharged from, a licensed nursing facility is exempt from a level of need determination and is eligible for nonemergency medical transportation services until the enrollee no longer resides in a licensed nursing facility, as provided in section 256B.04, subdivision 14a.

Subd. 17d. **Transportation services oversight.** The commissioner shall contract with a vendor or dedicate staff to oversee providers of nonemergency medical transportation services pursuant to the commissioner's authority in section 256B.04 and Minnesota Rules, parts 9505.2160 to 9505.2245.

Subd. 17e. **Transportation provider termination.** (a) A terminated nonemergency medical transportation provider, including all named individuals on the current enrollment disclosure form and known or discovered affiliates of the nonemergency medical transportation provider, is not eligible to enroll as a nonemergency medical transportation provider for five years following the termination.

(b) After the five-year period in paragraph (a), if a provider seeks to reenroll as a nonemergency medical transportation provider, the provider must be placed on a one-year probation period. During a provider's probation period the commissioner shall complete unannounced site visits and request documentation to review compliance with program requirements.

Subd. 18. **Public transit or taxicab transportation.** (a) 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.

(b) The commissioner may provide a monthly public transit pass to recipients who are well-served by public transit for the recipient's nonemergency medical transportation needs. Any recipient who is eligible for one public transit trip for a medically necessary covered service may select to receive a transit pass for that month. Recipients who do not have any transportation needs for a medically necessary service in any given month or who have received a transit pass for that month through another program administered by a county or Tribe are not eligible for a transit pass that month. The commissioner shall not require recipients to select a monthly transit pass if the recipient's transportation needs cannot be served by public transit systems. Recipients who receive a monthly transit pass are not eligible for other modes of transportation, unless an unexpected need arises that cannot be accessed through public transit.

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) 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 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.

[See Note.]

Subd. 18c. MS 2020 [Repealed, 2022 c 55 art 1 s 187]

Subd. 18d. MS 2020 [Repealed, 2022 c 55 art 1 s 187]

Subd. 18e. **Single administrative structure and delivery system.** The commissioner, in coordination with the commissioner of transportation, 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 and, if approved by the commissioner, shall be permanent thereafter.

[See Note.]

Subd. 18f. 2013 Supp [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 website. 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 website.

Subd. 18h. **Nonemergency medical transportation provisions related to managed care.** (a) The following nonemergency medical transportation (NEMT) subdivisions apply to managed care plans and county-based purchasing plans:

(1) subdivision 17, paragraphs (a), (b), (i), and (n);

(2) subdivision 18; and

(3) subdivision 18a.

(b) A nonemergency medical transportation provider must comply with the operating standards for special transportation service specified in sections 174.29 to 174.30 and Minnesota Rules, chapter 8840. Publicly operated transit systems, volunteers, and not-for-hire vehicles are exempt from the requirements in this paragraph.

(c) Managed care plans and county-based purchasing plans must provide a fuel adjustment for NEMT rates when fuel exceeds $3 per gallon. If, for any contract year, federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this paragraph. This paragraph expires if federal approval is not received for this paragraph at any time.

[See Note.]

Subd. 18i. **Administration of nonemergency medical transportation.** (a) Effective July 1, 2026, the commissioner must contract either statewide or regionally for the administration of the nonemergency medical transportation program in compliance with the provisions of this chapter. The contract must include the administration of the nonemergency medical transportation benefit for those enrolled in managed care as described in section 256B.69.

(b) The commissioner must provide six months' notice to counties, managed care organizations, and county-based purchasing organizations before implementing the administrator required under this subdivision.

(c) The commissioner must notify the revisor of statutes when the administrator under this subdivision is implemented.

Subd. 19. MS 1990 [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.

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.** (a) 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.

(b) "Qualified professional" means a mental health professional, 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 serious mental illness. 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) To be eligible for medical assistance reimbursement, an entity must document:

(1) face-to-face contacts between the case manager and the recipient;

(2) telephone contacts between the case manager and the recipient; the recipient's mental health provider or other service providers; the recipient's family members, legal representative, or primary caregiver; or other interested persons;

(3) face-to-face contacts between the case manager and the recipient's mental health provider or other service providers; the recipient's family members, legal representative, or primary caregiver; or other interested persons;

(4) contacts between the case manager and the case manager's clinical supervisor about the recipient;

(5) individual community support plan and assessment development, review, and revision required under section 245.4711, subdivision 4, for an adult, or section 245.4881, subdivision 4, for a child;

(6) travel time spent by the case manager to meet face-to-face with the recipient who resides outside of the county of financial responsibility; and

(7) travel time spent by the case manager within the county of financial responsibility to meet face-to-face with the recipient or the recipient's family, legal representative, or primary caregiver.

(c) For purposes of paragraph (b), clauses (6) and (7), if a case manager arrives on time for a scheduled face-to-face appointment with a recipient or the recipient's family member, legal representative, or primary caregiver and the person fails to keep the appointment, the time spent by the case manager traveling to and from the site of the scheduled appointment is eligible for medical assistance payment. Provider entities must meet all program standards set out in rules governing family community support services as defined in section 245.4871, subdivision 17, and Minnesota Rules, parts 9520.0900 to 9520.0926, and 9505.0322, subpart 9.

(d) Medical assistance and MinnesotaCare payment for mental health case management must be made in accordance with section 256B.076, subdivisions 1, 2, 5, and 6.

(e) Payment for mental health case management provided by county or state staff must be based on the rate methodology under section 256B.076, subdivisions 5 and 7.

(f) 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.

(g) Payment for mental health case management provided by vendors who contract with a county must be calculated in accordance with section 256B.076, subdivision 2. Payment for mental health case management provided by vendors who contract with a Tribe must be based on a monthly rate negotiated by the Tribe. The 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 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.

(h) 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.

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

(j) Notwithstanding any administrative rule to the contrary, prepaid medical assistance 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.

(k) The commissioner may suspend, reduce, or terminate the reimbursement to a provider that does not meet the requirements of this section or section 245.4711, 245.4881, 256B.0924, 256B.094, or 256F.10. The county of responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the Tribal agency, is responsible for any federal disallowances. The county or Tribe may share this responsibility with its contracted vendors.

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

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

(2) programming the information systems.

(m) 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.

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

(o) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital, and the recipient's institutional care is paid by medical assistance, payment for case management services under this subdivision is limited to the 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

(2) the limits and conditions which apply to federal Medicaid funding for this service.

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

(q) If the recipient is receiving care in a hospital, nursing facility, or residential setting licensed under chapter 245A or 245D that is staffed 24 hours a day, seven days a week, mental health targeted case management services must actively support identification of community alternatives for the recipient and discharge planning.

(r) Counties may receive payment for up to 12 15-minute units for use at case initiation and case closing to facilitate the recipient's needs assessments, individualized plan development, referrals, or case documentation without needing to meet the contact requirements specified under sections 245.4711, 245.4881, 256B.0924, 256B.094, and 256F.10.

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. 20b. **Targeted case management through interactive video.** (a) Minimum required face-to-face contacts for targeted case management may be provided through interactive video if interactive video is in the best interests of the person and is deemed appropriate by the person receiving targeted case management or the person's legal guardian and the case management provider.

(b) The person receiving targeted case management or the person's legal guardian has the right to choose and consent to the use of interactive video under this subdivision and has the right to refuse the use of interactive video at any time.

(c) The commissioner may establish criteria that a targeted case management provider must attest to in order to demonstrate the safety or efficacy of meeting the minimum face-to-face contact requirements for targeted case management through interactive video.

(d) As a condition of payment, the targeted case management provider must document the following for each occurrence of targeted case management provided by interactive video for the purpose of face-to-face contact:

(1) the time the contact began and the time the contact ended, including an a.m. and p.m. designation;

(2) the basis for determining that interactive video is an appropriate and effective means for contacting the person receiving targeted case management services;

(3) the mode of transmission used to deliver the services and records stating that a particular mode of transmission was utilized; and

(4) the location of the originating site and the distant site.

(e) Interactive video must not be used to meet minimum face-to-face contact requirements for children who are in out-of-home placement or receiving case management services for child protection reasons.

(f) For purposes of this subdivision, "interactive video" means the delivery of targeted case management services in real time through the use of two-way interactive audio and visual communication.

Subd. 21. MS 1998 [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. Hospice respite and end-of-life care under subdivision 22a are not hospice care services under this subdivision.

Subd. 22a. **Residential hospice facility; hospice respite and end-of-life care for children.** (a) Medical assistance covers hospice respite and end-of-life care if the care is for children who elect to receive hospice care delivered in a facility that is licensed under sections 144A.75 to 144A.755 and that is a residential

hospice facility under section 144A.75, subdivision 13, paragraph (a). Hospice care services under subdivision 22 are not hospice respite or end-of-life care under this subdivision.

(b) The payment rates for coverage under this subdivision must be 100 percent of the Medicare rate for continuous home care hospice services as published in the Centers for Medicare and Medicaid Services annual final rule updating payments and policies for hospice care. Payment for hospice respite and end-of-life care under this subdivision must be made from state money, though the commissioner must seek to obtain federal financial participation for the payments. Payment for hospice respite and end-of-life care must be paid to the residential hospice facility and are not included in any limit or cap amount applicable to hospice services payments to the elected hospice services provider.

(c) Certification of the residential hospice facility by the federal Medicare program must not be a requirement of medical assistance payment for hospice respite and end-of-life care under this subdivision.

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. 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. 24a. **Substance use disorder services.** Medical assistance covers substance use disorder treatment services according to sections 254B.0505 and 254B.0507, except for room and board.

Subd. 25. **Prior authorization required.** (a) The commissioner shall publish in the Minnesota health care programs provider manual and on the department's website 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;

(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, 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 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. 25c. **Applicability of utilization review provisions.** Effective January 1, 2026, the following provisions of chapter 62M apply to the commissioner when delivering services under chapters 256B and 256L: 62M.02, subdivisions 1 to 5, 7 to 12, 13, 14 to 18, and 21; 62M.04; 62M.05, subdivisions 1 to 4; 62M.06, subdivisions 1 to 3; 62M.07; 62M.072; 62M.09; 62M.10; 62M.12; 62M.17, subdivision 2; and 62M.18.

Subd. 26. **Special education services.** (a) Medical assistance covers evaluations necessary in making a determination for eligibility for individualized education program and individualized family service plan services and for medical services identified in a recipient's individualized education program and individualized family service plan and covered under the medical assistance state plan. Covered services include occupational therapy, physical therapy, speech-language therapy, clinical psychological services, nursing services, school psychological services, school social work services, personal care assistants serving as management aides, assistive technology devices, transportation services, 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, advanced practice registered nurse's, or physician assistant'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, advanced practice registered nurse, or physician assistant 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 Professional Educator Licensing and Standards Board as an educational speech-language pathologist; and

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

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

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

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

(i) Services provided by a school social worker as described in paragraph (l) must be provided by a mental health professional as defined in section 245I.04, subdivision 2; a clinical trainee as defined in section 245I.04, subdivision 6, under the supervision of a mental health professional; or a mental health practitioner as defined in section 245I.04, subdivision 4, under the supervision of a mental health professional, to be eligible for medical assistance reimbursement. Services described in paragraph (l) must be provided within the provider's scope of practice as defined in section 245I.04, subdivisions 3, 5, and 7.

(j) Notwithstanding section 245I.10, subdivision 2, a special education evaluation and assessment for and within an individual family service plan or individualized education program may be used to determine medical necessity for services described under paragraph (l). The special education evaluation and assessments for and within the individualized education program, or individual family service plan, that meet the requirements in section 245I.10, subdivisions 4, and 5 or 6, and that are completed by a licensed mental health professional or clinical trainee supervised by a licensed mental health professional can be used for determining medical necessity. In addition, for services that do not require a diagnosis using an assessment as defined in section 245I.10, subdivisions 4, and 5 or 6, the special education evaluation and assessments for and within the individualized education program, or individual family service plan, that provide an International Classification of Diseases diagnostic code and are completed by a licensed mental health professional or clinical trainee supervised by a licensed mental health professional can be used for determining medical necessity.

(k) A school social worker or school providing services under paragraph (l) is not required to be certified to provide children's therapeutic services and supports under section 256B.0943.

(l) Covered services provided by a school social worker under this paragraph are:

(1) the explanation of findings as described in section 256B.0671, subdivision 4;

(2) psychotherapy for crisis as described in section 256B.0671, subdivision 11a;

(3) children's mental health clinical care consultation, as described in section 256B.0671, subdivision 7;

(4) dialectical behavioral therapy for adolescents, as described in section 256B.0671, subdivision 6;

(5) family psychoeducation, as described in section 256B.0671, subdivision 5, which includes skill development, peer group sessions, and individual sessions. Notwithstanding section 256B.0671, subdivision 5, family psychoeducation services under this section may be delivered by a mental health practitioner as defined under section 245I.04, subdivision 4; and

(6) individual, family, and group psychotherapy, as described in section 256B.0671, subdivision 11.

[See Note.]

Subd. 27. **Organ and tissue transplants.** Organ and tissue transplants are a covered service. Stem cell or bone marrow transplant centers must meet the standards established by the Foundation for the Accreditation of Hematopoietic Cell Therapy.

Subd. 28. **Advanced practice registered nurse services.** Medical assistance covers services performed by a certified pediatric advanced practice registered nurse, a certified family advanced practice registered nurse, a certified adult advanced practice registered nurse, a certified obstetric/gynecological advanced practice registered nurse, a certified neonatal advanced practice registered nurse, or a certified geriatric advanced practice registered nurse 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 advanced practice registered nurse'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 may bill for medication management and evaluation and management services provided to medical assistance enrollees in inpatient hospital settings, and in outpatient settings after the licensed physician assistant completes 2,000 hours of clinical experience in the evaluation and treatment of mental health, consistent with their education, training, and experience, with the exception of performing psychotherapy or diagnostic assessments.

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. The commissioner shall enroll doula agencies and individual treating doulas to provide direct reimbursement.

Subd. 28c. **Certified midwifery practice services.** Medical assistance covers services performed by a licensed certified midwife if:

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

(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 certified midwife's license as defined under chapter 148G.

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 (FQHC) 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. An FQHC 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, an FQHC 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. FQHCs 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), an FQHC 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 FQHCs 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 FQHCs 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 FQHCs or rural health clinics.

(d) Effective July 1, 1999, the provisions of paragraph (c) requiring an FQHC 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, through December 31, 2020, each FQHC and rural health clinic may elect to be paid either under the prospective payment system established in United States Code, title 42, section

1396a(aa), or under an alternative payment methodology consistent with the requirements of United States Code, title 42, section 1396a(aa), and approved by the Centers for Medicare and Medicaid Services. The alternative payment methodology shall be 100 percent of cost as determined according to Medicare cost principles.

(g) Effective for services provided on or after January 1, 2021, all claims for payment of clinic services provided by FQHCs and rural health clinics shall be paid by the commissioner, according to an annual election by the FQHC or rural health clinic, under the current prospective payment system described in paragraph (f) or the alternative payment methodology described in paragraph (l), or, upon federal approval, for FQHCs that are also urban Indian organizations under Title V of the federal Indian Health Improvement Act, as provided under paragraph (k).

(h) 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.

(i) Effective for services provided on or after January 1, 2015, all claims for payment of clinic services provided by FQHCs 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) FQHCs 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) FQHCs 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.

(j) 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.

(k) The commissioner shall establish an encounter payment rate that is equivalent to the all inclusive rate (AIR) payment established by the Indian Health Service and published in the Federal Register. The encounter rate must be updated annually and must reflect the changes in the AIR established by the Indian Health Service each calendar year. FQHCs that are also urban Indian organizations under Title V of the federal Indian Health Improvement Act may elect to be paid: (1) at the encounter rate established under this paragraph; (2) under the alternative payment methodology described in paragraph (l); or (3) under the federally required prospective payment system described in paragraph (f). FQHCs that elect to be paid at the encounter rate established under this paragraph must continue to meet all state and federal requirements related to FQHCs and urban Indian organizations, and must maintain their statuses as FQHCs and urban Indian organizations.

(l) All claims for payment of clinic services provided by FQHCs and rural health clinics, that have elected to be paid under this paragraph, shall be paid by the commissioner according to the following requirements:

(1) the commissioner shall establish a single medical and single dental organization encounter rate for each FQHC and rural health clinic when applicable;

(2) each FQHC and rural health clinic is eligible for same day reimbursement of one medical and one dental organization encounter rate if eligible medical and dental visits are provided on the same day;

(3) the commissioner shall reimburse FQHCs and rural health clinics, in accordance with current applicable Medicare cost principles, their allowable costs, including direct patient care costs and patient-related support services. Nonallowable costs include, but are not limited to:

(i) general social services and administrative costs;

(ii) retail pharmacy;

(iii) patient incentives, food, housing assistance, and utility assistance;

(iv) external lab and x-ray;

(v) navigation services;

(vi) health care taxes;

(vii) advertising, public relations, and marketing;

(viii) office entertainment costs, food, alcohol, and gifts;

(ix) contributions and donations;

(x) bad debts or losses on awards or contracts;

(xi) fines, penalties, damages, or other settlements;

(xii) fundraising, investment management, and associated administrative costs;

(xiii) research and associated administrative costs;

(xiv) nonpaid workers;

(xv) lobbying;

(xvi) scholarships and student aid; and

(xvii) nonmedical assistance covered services;

(4) the commissioner shall review the list of nonallowable costs in the years between the rebasing process established in clause (5), in consultation with the Minnesota Association of Community Health Centers, FQHCs, and rural health clinics. The commissioner shall publish the list and any updates in the Minnesota health care programs provider manual;

(5) the initial applicable base year organization encounter rates for FQHCs and rural health clinics shall be computed for services delivered on or after January 1, 2021, and:

(i) must be determined using each FQHC's and rural health clinic's Medicare cost reports from 2017 and 2018;

(ii) must be according to current applicable Medicare cost principles as applicable to FQHCs and rural health clinics without the application of productivity screens and upper payment limits or the Medicare prospective payment system FQHC aggregate mean upper payment limit;

(iii) must be subsequently rebased every two years thereafter using the Medicare cost reports that are three and four years prior to the rebasing year. Years in which organizational cost or claims volume is reduced or altered due to a pandemic, disease, or other public health emergency shall not be used as part of a base year when the base year includes more than one year. The commissioner may use the Medicare cost reports of a year unaffected by a pandemic, disease, or other public health emergency, or previous two consecutive years, inflated to the base year as established under item (iv);

(iv) must be inflated to the base year using the inflation factor described in clause (6); and

(v) the commissioner must provide for a 60-day appeals process under section 14.57;

(6) the commissioner shall annually inflate the applicable organization encounter rates for FQHCs and rural health clinics from the base year payment rate to the effective date by using the CMS FQHC Market Basket inflator established under United States Code, title 42, section 1395m(o), less productivity;

(7) FQHCs and rural health clinics that have elected the alternative payment methodology under this paragraph shall submit all necessary documentation required by the commissioner to compute the rebased organization encounter rates no later than six months following the date the applicable Medicare cost reports are due to the Centers for Medicare and Medicaid Services;

(8) the commissioner shall reimburse FQHCs and rural health clinics an additional amount relative to their medical and dental organization encounter rates that is attributable to the tax required to be paid according to section 295.52, if applicable;

(9) FQHCs and rural health clinics may submit change of scope requests to the commissioner if the change of scope would result in an increase or decrease of 2.5 percent or higher in the medical or dental organization encounter rate currently received by the FQHC or rural health clinic;

(10) for FQHCs and rural health clinics seeking a change in scope with the commissioner under clause (9) that requires the approval of the scope change by the federal Health Resources Services Administration:

(i) FQHCs and rural health clinics shall submit the change of scope request, including the start date of services, to the commissioner within seven business days of submission of the scope change to the federal Health Resources Services Administration;

(ii) the commissioner shall establish the effective date of the payment change as the federal Health Resources Services Administration date of approval of the FQHC's or rural health clinic's scope change request, or the effective start date of services, whichever is later; and

(iii) within 45 days of one year after the effective date established in item (ii), the commissioner shall conduct a retroactive review to determine if the actual costs established under clause (3) or encounters result in an increase or decrease of 2.5 percent or higher in the medical or dental organization encounter rate, and if this is the case, the commissioner shall revise the rate accordingly and shall adjust payments retrospectively to the effective date established in item (ii);

(11) for change of scope requests that do not require federal Health Resources Services Administration approval, the FQHC and rural health clinic shall submit the request to the commissioner before implementing the change, and the effective date of the change is the date the commissioner received the FQHC's or rural health clinic's request, or the effective start date of the service, whichever is later. The commissioner shall provide a response to the FQHC's or rural health clinic's request within 45 days of submission and provide a final approval within 120 days of submission. This timeline may be waived at the mutual agreement of the commissioner and the FQHC or rural health clinic if more information is needed to evaluate the request;

(12) the commissioner, when establishing organization encounter rates for new FQHCs and rural health clinics, shall consider the patient caseload of existing FQHCs and rural health clinics in a 60-mile radius for organizations established outside of the seven-county metropolitan area, and in a 30-mile radius for organizations in the seven-county metropolitan area. If this information is not available, the commissioner may use Medicare cost reports or audited financial statements to establish base rates;

(13) the commissioner, when establishing organization encounter rates under this section for FQHCs and rural health clinics resulting from a merger of existing clinics or the acquisition of an existing clinic by another existing clinic, must use the combined costs and caseloads from the clinics participating in the merger or acquisition to set the encounter rate for the new clinic organization resulting from the merger or acquisition. The scope of services for the newly formed clinic must be inclusive of the scope of services of the clinics participating in the merger or acquisition;

(14) the commissioner shall establish a quality measures workgroup that includes representatives from the Minnesota Association of Community Health Centers, FQHCs, and rural health clinics, to evaluate clinical and nonclinical measures; and

(15) the commissioner shall not disallow or reduce costs that are related to an FQHC's or rural health clinic's participation in health care educational programs to the extent that the costs are not accounted for in the alternative payment methodology encounter rate established in this paragraph.

(m) Effective July 1, 2023, an enrolled Indian health service facility or a Tribal health center operating under a 638 contract or compact may elect to also enroll as a Tribal FQHC. Requirements that otherwise apply to an FQHC covered in this subdivision do not apply to a Tribal FQHC enrolled under this paragraph, except that any requirements necessary to comply with federal regulations do apply to a Tribal FQHC. The commissioner shall establish an alternative payment method for a Tribal FQHC enrolled under this paragraph that uses the same method and rates applicable to a Tribal facility or health center that does not enroll as a Tribal FQHC.

(n) FQHC reimbursement for mental health targeted case management services is limited to:

(1) only those services described under subdivision 20 and provided in accordance with contracts executed with counties authorized to subcontract for mental health targeted case management services; and

(2) an FQHC's actual incurred costs as separately reported on the cost report submitted to the Centers for Medicare and Medicaid Services and further identified in reports submitted to the commissioner.

(o) Counties contracting with FQHCs for mental health targeted case management remain responsible for the nonfederal share of the cost of the provided mental health targeted case management services. The commissioner must bill each county for the nonfederal share of the mental health targeted case management costs as reported by the FQHC.

[See Note.]

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.

(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.

(f) Notwithstanding the requirement in paragraph (e) that an electronic tablet must be locked to prevent use not as an augmentative communication device, a recipient of waiver services may use an electronic

tablet for a use not related to communication when the recipient has been authorized under the waiver to receive one or more additional applications that can be loaded onto the electronic tablet, such that allowing the additional use prevents the purchase of a separate electronic tablet with waiver funds.

(g) An order or prescription for medical supplies, equipment, or appliances must meet the requirements in Code of Federal Regulations, title 42, part 440.70.

(h) Allergen-reducing products provided according to subdivision 67, paragraph (c) or (d), shall be considered durable medical equipment.

(i) Seizure detection devices are covered as durable medical equipment under this subdivision if:

(1) the seizure detection device is medically appropriate based on the recipient's medical condition or status; and

(2) the recipient's health care provider has identified that a seizure detection device would:

(i) likely assist in reducing bodily harm to or death of the recipient as a result of the recipient experiencing a seizure; or

(ii) provide data to the health care provider necessary to appropriately diagnose or treat a health condition of the recipient that causes the seizure activity.

(j) For purposes of paragraph (i), "seizure detection device" means a United States Food and Drug Administration-approved monitoring device and related service or subscription supporting the prescribed use of the device, including technology that provides ongoing patient monitoring and alert services that detect seizure activity and transmit notification of the seizure activity to a caregiver for appropriate medical response or collects data of the seizure activity of the recipient that can be used by a health care provider to diagnose or appropriately treat a health care condition that causes the seizure activity. The medical assistance reimbursement rate for a subscription supporting the prescribed use of a seizure detection device is 60 percent of the rate for monthly remote monitoring under the medical assistance telemonitoring benefit.

[See Note.]

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.

(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 website.

(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. 31c. MS 2018 [Repealed, 1Sp2019 c 9 art 7 s 47]

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. Medical assistance covers amino acid-based elemental formulas in the same manner as is required under section 62Q.531. 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 260E.03, subdivision 12; or

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

Subd. 34. **Indian health services facilities.** Medical assistance payments and MinnesotaCare payments to facilities of the Indian health service and facilities operated by a Tribe or Tribal organization under funding authorized by United States Code, title 25, sections 450f to 450n, or title III of the Indian Self-Determination and Education Assistance Act, Public Law 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).

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. MS 2002 [Repealed, 1Sp2003 c 14 art 4 s 24]

Subd. 35a. MS 2020 [Repealed, 2021 c 30 art 17 s 113]

Subd. 35b. MS 2020 [Repealed, 2021 c 30 art 17 s 113]

Subd. 36. MS 2002 [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.

[See Note.]

Subd. 39. **Childhood immunizations.** (a) 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 unless the vaccines qualify for 100 percent federal funding or are mandated by the Centers for Medicare and Medicaid Services to be covered outside of the Vaccines for Children program.

(b) Medical assistance covers vaccines initiated, ordered, or administered by a licensed pharmacist, according to the requirements of section 151.01, subdivision 27, clause (6), at no less than the rate for which the same services are covered when provided by any other licensed practitioner.

[See Note.]

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:

(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 serious mental illness.** 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 serious mental illness 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 qualified according to section 245I.04, subdivision 2, for the purpose of this section and Minnesota Rules, parts 9505.0170 to 9505.0475.

Subd. 43. **Mental health provider travel time.** (a) Medical assistance covers provider travel time if a recipient requires the provision of mental health services outside of the provider's usual place of business.

(b) Medical assistance covers under this subdivision the time a provider is in transit to provide a covered mental health service to a recipient at a location that is not the provider's usual place of business. A provider must travel the most direct route available. Mental health provider travel time does not include time for scheduled or unscheduled stops, meal breaks, or vehicle maintenance or repair, including refueling or vehicle emergencies. Recipient transportation is not covered under this subdivision.

(c) Mental health provider travel time under this subdivision is only covered when the mental health service being provided is covered under medical assistance and only when the covered mental health service is delivered and billed. Mental health provider travel time is not covered when the mental health service being provided otherwise includes provider travel time or when the service is site based.

(d) A provider must document each trip for which the provider seeks reimbursement under this subdivision in a compiled travel record. Required documentation may be collected and maintained electronically or in paper form but must be made available and produced upon request by the commissioner. The travel record must be written in English and must be legible according to the standard of a reasonable person. The recipient's individual identification number must be on each page of the record. The reason the provider must travel to provide services must be included in the record, if not otherwise documented in the recipient's individual treatment plan. Each entry in the record must document:

(1) start and stop time (with a.m. and p.m. notations);

(2) printed name of the recipient;

(3) date the entry is made;

(4) date the service is provided;

(5) origination site and destination site;

(6) who provided the service;

(7) the electronic source used to calculate driving directions and distance between locations; and

(8) the medically necessary mental health service delivered.

(e) Mental health providers identified by the commissioner to have submitted a fraudulent report may be excluded from participation in Minnesota health care programs.

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. 45a. **Psychiatric residential treatment facility services for persons younger than 21 years of age.** (a) Medical assistance covers psychiatric residential treatment facility services, according to section 256B.0941, for persons younger than 21 years of age. Individuals who reach age 21 at the time they are receiving services are eligible to continue receiving services until they no longer require services or until they reach age 22, whichever occurs first.

(b) For purposes of this subdivision, "psychiatric residential treatment facility" means a facility other than a hospital that provides psychiatric services, as described in Code of Federal Regulations, title 42, sections 441.151 to 441.182, to individuals under age 21 in an inpatient setting.

(c) The commissioner shall enroll up to 150 certified psychiatric residential treatment facility services beds. The commissioner may enroll an additional 80 certified psychiatric residential treatment facility services beds beginning July 1, 2020, and an additional 70 certified psychiatric residential treatment facility services beds beginning July 1, 2023. The commissioner shall select psychiatric residential treatment facility services providers through a request for proposals process. Providers of state-operated services may respond to the request for proposals. The commissioner shall prioritize programs that demonstrate the capacity to serve children and youth with aggressive and risky behaviors toward themselves or others, multiple diagnoses, neurodevelopmental disorders, or complex trauma related issues.

Subd. 46. **Mental health telehealth.** Subject to federal approval, mental health services that are otherwise covered by medical assistance as direct face-to-face services may be provided via telehealth in accordance with subdivision 3b.

Subd. 47. **Children's intensive behavioral health services.** Medical assistance covers children's intensive behavioral health services according to section 256B.0946.

Subd. 48. **Mental health consultation to primary care practitioners.** Medical assistance covers consultation provided by a mental health professional qualified according to section 245I.04, subdivision 2, except a licensed professional clinical counselor licensed under section 148B.5301, via telephone, email, 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 received a certificate from the Minnesota State Colleges and Universities System approved community health worker curriculum.

(b) Community health workers must work under the supervision of a medical assistance enrolled physician, registered nurse, advanced practice registered nurse, physician assistant, mental health professional, 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. MS 2014 [Repealed, 2015 c 21 art 1 s 110]

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 subdivision, 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 (b).

(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 Advisory Council 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.]

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 100 percent of the hospital facility fee cost trended to current 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 100 percent of the hospital facility fee cost trended to current for an uncomplicated vaginal delivery as determined using the most recent calendar year for which complete claims data is available.

(c) Facility services provided to a newborn by a birth center shall be paid the lower of billed charges or 100 percent of the hospital facility fee for a normal newborn as determined using the most recent calendar year for which complete claims data is available, cost trended to current.

(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) Licensed health professionals working in licensed birth centers shall be reimbursed for the full range of maternity care and newborn care services within their scope of practice, regardless of place of service. The commissioner shall review current birth center reimbursement and, in consultation with birth centers

currently licensed in the state, develop revisions to current payment practices in order to ensure reimbursement for the full range of maternity care and newborn care services, including but not limited to:

(1) professional services for intrapartum care when a recipient is transferred from a birth center to a hospital prior to delivery;

(2) professional services billed with a home place of service code by a licensed health professional within their scope of practice;

(3) professional services when a licensed health professional provides any Minnesota-mandated newborn screening, including but not limited to the newborn metabolic screen, CCHD screening, hearing screen, or any other medically necessary newborn screening, test, or assessment; and

(4) telehealth services provided by any licensed health professional working in a birth center.

(f) Managed care organizations and county-based purchasing plans contracted to provide medical assistance coverage under section 256B.69 shall reimburse licensed birth centers and licensed health professionals working in licensed birth centers for the full range of maternity care services within their scope of practice, regardless of place of service, as determined in paragraph (e) at no less than the medical assistance fee for service fee schedule for the year in which the service is provided. If, for any contract year, federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this paragraph. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this paragraph. This paragraph expires if federal approval is not received for this paragraph at any time.

(g) 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.

[See Note.]

Subd. 54a. **Home birth.** (a) For purposes of this subdivision, the following terms have the meanings given:

(1) "birth services" means prenatal, labor, birth, and postpartum services;

(2) "eligible provider" means a licensed or certified health care professional eligible for reimbursement under the medical assistance program; and

(3) "low-risk patient for birth services" means a person undergoing a normal, uncomplicated prenatal course as determined by documentation of adequate prenatal care whose treating provider anticipates a normal, uncomplicated labor and birth, as defined by reasonable and generally accepted criteria adopted by professional groups for maternal, fetal, and neonatal health care.

(b) Medical assistance covers birth services provided at home when the following conditions are met:

(1) the birth services are provided by an eligible provider whose scope of practice and experience includes home birth;

(2) the recipient is a low-risk patient for birth services; and

(3) the recipient has a plan of care that includes:

(i) a consent form detailing the risks and benefits of home birth signed by the recipient;

(ii) sufficient visits, test results, and follow-up consultations as needed to establish that the recipient is a low-risk patient for birth services; and

(iii) a plan for transfer to a hospital as needed.

(c) Services provided under this subdivision by an eligible provider must be paid at a rate at least equal to 100 percent of the rate paid to a physician performing the same services. An eligible provider who does not perform the delivery must not bill for any delivery services.

(d) Supplies used for birth services under this subdivision must be paid at 70 percent of the statewide average for a facility payment rate made to a hospital for an uncomplicated vaginal delivery as determined using the most recent calendar year for which complete claims data are available. If a recipient is transported from a home to a hospital prior to the delivery, the payment for the supplies used for birth services under this subdivision must be the lower of billed charges or 15 percent of the statewide average for a facility payment rate 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 are available.

[See Note.]

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 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 health care 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 mental illness 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 mental illness, 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 services and payments provided under in-reach care coordination do not duplicate services or payments provided under subdivision 20 or section 256B.0753 or 256B.0755.

Subd. 56a. **Officer-involved community-based care coordination.** (a) Medical assistance covers officer-involved community-based care coordination for an individual who:

(1) has screened positive for benefiting from treatment for a mental illness or substance use disorder using a tool approved by the commissioner;

(2) does not require the security of a public detention facility and is not considered an inmate of a public institution as defined in Code of Federal Regulations, title 42, section 435.1010;

(3) meets the eligibility requirements in section 256B.056; and

(4) has agreed to participate in officer-involved community-based care coordination.

(b) Officer-involved community-based care coordination means 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 jail utilization and connecting individuals with existing covered services available to them, including, but not limited to, targeted case management, waiver case management, or care coordination.

(c) Officer-involved community-based care coordination must be provided by an individual who is an employee of or is under contract with a county, or is an employee of or under contract with 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 to provide officer-involved community-based care coordination and is qualified under one of the following criteria:

(1) a mental health professional;

(2) a clinical trainee qualified according to section 245I.04, subdivision 6, working under the treatment supervision of a mental health professional according to section 245I.06;

(3) a mental health practitioner qualified according to section 245I.04, subdivision 4, working under the treatment supervision of a mental health professional according to section 245I.06;

(4) a mental health certified peer specialist qualified according to section 245I.04, subdivision 10, working under the treatment supervision of a mental health professional according to section 245I.06;

(5) an individual qualified as an alcohol and drug counselor under section 245G.11, subdivision 5; or

(6) a recovery peer qualified under section 245G.11, subdivision 8, working under the supervision of an individual qualified as an alcohol and drug counselor under section 245G.11, subdivision 5.

(d) Reimbursement is allowed for up to 60 days following the initial determination of eligibility.

(e) Providers of officer-involved community-based care coordination shall annually report to the commissioner on the number of individuals served, and number of the community-based services that were accessed by recipients. The commissioner shall ensure that services and payments provided under officer-involved community-based care coordination do not duplicate services or payments provided under section 256B.0625, subdivision 20, 256B.0753, 256B.0755, or 256B.0757.

[See Note.]

Subd. 57. **Payment for Part B Medicare crossover claims.** (a) 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.

(b) 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 registered nurses with a specialty in mental health.

(c) Excluded from this limitation are payments to federally qualified health centers, Indian Health Services, rural health clinics, and CCBHCs subject to the prospective payment system under subdivision 5m.

Subd. 57a. **Payment limitation for Medicare-covered skilled nursing facility stays.** For services rendered on or after July 1, 2003, for facilities reimbursed under this chapter or chapter 256R, 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 case mix adjusted total payment rate under chapter 256R. The amount that shall be paid by the Medicaid program is equal to the amount by which the case mix adjusted total 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. 58. **Early and periodic screening, diagnosis, and treatment services.** (a) Medical assistance covers early and periodic screening, diagnosis, and treatment services (EPSDT). In administering the EPSDT program, the commissioner shall, at a minimum:

(1) provide information to children and families, using the most effective mode identified, regarding:

(i) the benefits of preventative health care visits;

(ii) the services available as part of the EPSDT program; and

(iii) assistance finding a provider, transportation, or interpreter services;

(2) maintain an up-to-date periodicity schedule published in the department policy manual, taking into consideration the most up-to-date community standard of care; and

(3) maintain up-to-date policies for providers on the delivery of EPSDT services that are in the provider manual on the department website.

(b) The commissioner may contract for the administration of the outreach services as required within the EPSDT program.

(c) The commissioner may contract for the required EPSDT outreach services, including but not limited to children enrolled or attributed to an integrated health partnership demonstration project described in section 256B.0755. Integrated health partnerships that choose to include the EPSDT outreach services within the integrated health partnership's contracted responsibilities must receive compensation from the commissioner on a per-member per-month basis for each included child. Integrated health partnerships must accept responsibility for the effectiveness of outreach services it delivers. For children who are not a part of the demonstration project, the commissioner may contract for the administration of the outreach services.

(d) The payment amount for a complete EPSDT screening shall not include charges for health care services and products 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. 60a. **Community emergency medical technician services.** (a) Medical assistance covers services provided by a community emergency medical technician (CEMT) who is certified under section 144E.275, subdivision 7, when the services are provided in accordance with this subdivision.

(b) A CEMT may provide a postdischarge visit, after discharge from a hospital or skilled nursing facility, when ordered by a treating physician, advanced practice registered nurse, or physician assistant. The postdischarge visit includes:

(1) verbal or visual reminders of discharge orders;

(2) recording and reporting of vital signs to the patient's primary care provider;

(3) medication access confirmation;

(4) food access confirmation; and

(5) identification of home hazards.

(c) An individual who has repeat ambulance calls due to falls or has been identified by the individual's primary care provider as at risk for nursing home placement, may receive a safety evaluation visit from a CEMT when ordered by a primary care provider in accordance with the individual's care plan. A safety evaluation visit includes:

(1) medication access confirmation;

(2) food access confirmation; and

(3) identification of home hazards.

(d) A CEMT shall be paid at $9.75 per 15-minute increment. A safety evaluation visit may not be billed for the same day as a postdischarge visit for the same individual.

Subd. 61. MS 2020 [Repealed, 2021 c 30 art 17 s 113]

Subd. 62. MS 2020 [Repealed, 2021 c 30 art 17 s 113]

Subd. 63. MS 2018 [Repealed, 1Sp2019 c 9 art 7 s 47]

Subd. 64. **Investigational drugs, biological products, devices, and clinical trials.** Medical assistance and the early periodic screening, diagnosis, and treatment (EPSDT) program do not cover investigational drugs, biological products, or devices as defined in section 151.375 or any other treatment that is part of an approved clinical trial as defined in section 62Q.526. Participation of an enrollee in an approved clinical trial does not preclude coverage of medically necessary services covered under this chapter that are not related to the approved clinical trial. Any items or services that are provided solely to satisfy data collection and analysis for a clinical trial, and not for direct clinical management of the enrollee, are not covered.

Subd. 65. MS 2020 [Repealed, 2021 c 30 art 17 s 113]

Subd. 66. **Coverage for treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset neuropsychiatric syndrome (PANS).** Medical assistance covers treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset neuropsychiatric syndrome (PANS). Coverage shall be developed in collaboration with the Health Services Advisory Council established under subdivision 3c.

Subd. 67. **Enhanced asthma care services.** (a) Medical assistance covers enhanced asthma care services and related products to be provided in the children's homes for children with poorly controlled asthma. To be eligible for services and products under this subdivision, a child must:

(1) have poorly controlled asthma defined by having received health care for the child's asthma from a hospital emergency department at least one time in the past year or have been hospitalized for the treatment of asthma at least one time in the past year; and

(2) receive a referral for services and products under this subdivision from a treating health care provider.

(b) Covered services include home visits provided by a registered environmental health specialist or lead risk assessor currently credentialed by the Department of Health or a healthy homes specialist credentialed by the Building Performance Institute.

(c) Covered products include the following allergen-reducing products that are identified as needed and recommended for the child by a registered environmental health specialist, healthy homes specialist, lead risk assessor, certified asthma educator, public health nurse, or other health care professional providing asthma care for the child, and proven to reduce asthma triggers:

(1) allergen encasements for mattresses, box springs, and pillows;

(2) an allergen-rated vacuum cleaner, filters, and bags;

(3) a dehumidifier and filters;

(4) HEPA single-room air cleaners and filters;

(5) integrated pest management, including traps and starter packages of food storage containers;

(6) a damp mopping system;

(7) if the child does not have access to a bed, a waterproof hospital-grade mattress; and

(8) for homeowners only, furnace filters.

(d) The commissioner shall determine additional products that may be covered as new best practices for asthma care are identified.

(e) A home assessment is a home visit to identify asthma triggers in the home and to provide education on trigger-reducing products. A child is limited to two home assessments except that a child may receive an additional home assessment if the child moves to a new home; if a new asthma trigger, including tobacco smoke, enters the home; or if the child's health care provider identifies a new allergy for the child, including an allergy to mold, pests, pets, or dust mites. The commissioner shall determine the frequency with which a child may receive a product under paragraph (c) or (d) based on the reasonable expected lifetime of the product.

Subd. 68. **Tobacco and nicotine cessation.** (a) Medical assistance covers tobacco and nicotine cessation services, drugs to treat tobacco and nicotine addiction or dependence, and drugs to help individuals discontinue use of tobacco and nicotine products. Medical assistance must cover services and drugs as provided in this subdivision consistent with evidence-based or evidence-informed best practices.

(b) Medical assistance must cover in-person individual and group tobacco and nicotine cessation education and counseling services if provided by a health care practitioner whose scope of practice encompasses tobacco and nicotine cessation education and counseling. Service providers include but are not limited to the following:

(1) mental health practitioners under section 245.462, subdivision 17;

(2) mental health professionals under section 245.462, subdivision 18;

(3) mental health certified peer specialists under section 256B.0615;

(4) alcohol and drug counselors licensed under chapter 148F;

(5) recovery peers as defined in section 245F.02, subdivision 21;

(6) certified tobacco treatment specialists;

(7) community health workers;

(8) physicians;

(9) physician assistants;

(10) advanced practice registered nurses; or

(11) other licensed or nonlicensed professionals or paraprofessionals with training in providing tobacco and nicotine cessation education and counseling services.

(c) Medical assistance covers telephone cessation counseling services provided through a quitline. Notwithstanding section 256B.0625, subdivision 3b, quitline services may be provided through audio-only

communications. The commissioner of human services may utilize volume purchasing for quitline services consistent with section 256B.04, subdivision 14.

(d) Medical assistance must cover all prescription and over-the-counter pharmacotherapy drugs approved by the United States Food and Drug Administration for cessation of tobacco and nicotine use or treatment of tobacco and nicotine dependence, and that are subject to a Medicaid drug rebate agreement.

(e) Services covered under this subdivision may be provided by telemedicine.

(f) The commissioner must not:

(1) restrict or limit the type, duration, or frequency of tobacco and nicotine cessation services;

(2) prohibit the simultaneous use of multiple cessation services, including but not limited to simultaneous use of counseling and drugs;

(3) require counseling before receiving drugs or as a condition of receiving drugs;

(4) limit pharmacotherapy drug dosage amounts for a dosing regimen for treatment of a medically accepted indication as defined in United States Code, title 14, section 1396r-8(K)(6); limit dosing frequency; or impose duration limits;

(5) prohibit simultaneous use of multiple drugs, including prescription and over-the-counter drugs;

(6) require or authorize step therapy; or

(7) require or utilize prior authorization for any tobacco and nicotine cessation services and drugs covered under this subdivision.

Subd. 69. **Biomarker testing.** Medical assistance covers biomarker testing to diagnose, treat, manage, and monitor illness or disease. Medical assistance coverage must meet the requirements that would otherwise apply to a health plan under section 62Q.473.

[See Note.]

Subd. 70. **Recuperative care services.** Medical assistance covers recuperative care services according to section 256B.0701.

Subd. 71. **Coverage of services for the diagnosis, monitoring, and treatment of rare diseases.** (a) Medical assistance covers services related to the diagnosis, monitoring, and treatment of a rare disease or condition. Medical assistance coverage for these services must meet the requirements in section 62Q.451, subdivisions 1 to 3 and 6. Providers must still meet all applicable program requirements.

(b) Coverage for a service must not be denied solely on the basis that it was provided by, referred for, or ordered by an out-of-network provider.

(c) Any prior authorization requirements for a service that is provided by, referred for, or ordered by an out-of-network provider must be the same as any prior authorization requirements for a service that is provided by, referred for, or ordered by an in-network provider.

(d) Nothing in this subdivision requires medical assistance to cover additional services.

Subd. 72. **Orthotic and prosthetic devices.** Medical assistance covers orthotic and prosthetic devices, supplies, and services according to section 256B.066.

[See Note.]

Subd. 73. **Rapid whole genome sequencing.** Medical assistance covers rapid whole genome sequencing (rWGS) testing. Coverage and eligibility for rWGS testing, and the use of genetic data, must meet the requirements specified in section 62A.3098, subdivisions 1 to 3 and 6.

Subd. 74. **Intermittent catheters.** Medical assistance covers intermittent urinary catheters and insertion supplies if intermittent catheterization is recommended by the enrollee's health care provider. Medical assistance must meet the requirements that would otherwise apply to a health plan under section 62Q.666.

Subd. 75. **Scalp hair prostheses.** Medical assistance covers scalp hair prostheses and all equipment and accessories necessary for their regular use under the conditions and in compliance with the requirements specified in section 62A.28, except that the limitation on coverage required per benefit year set forth in section 62A.28, subdivision 2, paragraph (c), does not apply.

Subd. 76. **Transfer of mothers and newborns.** Medical assistance covers the transfer of mothers or newborns between medical facilities. Medical assistance must meet the same requirements that would otherwise apply to a health plan under section 62A.0411.

Subd. 77. **Early intensive developmental and behavioral intervention benefit.** Medical assistance covers early intensive developmental and behavioral intervention services according to section 256B.0949.

Subd. 78. **Carceral targeted case management.** Effective January 1, 2028, or upon federal approval, whichever is later, medical assistance covers carceral targeted case management services under section 256B.0619.

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 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; 2015 c 15 s 2; 2015 c 71 art 2 s 34,35; art 9 s 13-15; art 11 s 19-28; 2015 c 78 art 4 s 52,61; art 5 s 2; 2016 c 99 art 2 s 3; 2016 c 158 art 1 s 111; art 2 s 85-89; 2016 c 164 s 7; 2016 c 189 art 19 s 10-13; 2017 c 53 s 1; 1Sp2017 c 5 art 4 s 8; art 12 s 22; 1Sp2017 c 6 art 1 s 5,6; art 4 s 26-37; art 8 s 68; 2018 c 128 s 7; 2018 c 164 s 2; 2018 c 170 s 9; 2018 c 182 art 1 s 49; 2019 c 42 s 3,4; 2019 c 57 s 1; 1Sp2019 c 9 art 6 s 52-57; art 7 s 23-31; art 8 s 17,18; 2020 c 115 art 2 s 28,29; art 3 s 26-28; art 4 s 115-120; 1Sp2020 c 2 art 2 s 12,13; art 5 s 38; art 8 s 91; 2021 c 30 art 1 s 8-11,24; art 11 s 4; art 17 s 71-78; 1Sp2021 c 4 art 3 s 27; art 6 s 19; 1Sp2021 c 7 art 1 s 7-16; art 3 s 41; art 6 s 11-16,28,29; art 11 s 17; 1Sp2021 c 11 art 4 s 31; 2022 c 55 art 1 s 129,130; 2022 c 58 s 138-144; 2022 c 98 art 2 s 9; art 4 s 32; art 6 s 7; 2022 c 99 art 1 s 16; 2023 c 25 s 138,139; 2023 c 28 s 2; 2023 c 50 art 4 s 4; 2023 c 55 art 7 s 16; 2023 c 61 art 3 s 5-10; 2023 c 63 art 6 s 45; 2023 c 70 art 1 s 11-26; art 17 s 43; art 18 s 21; 2024 c 85 s 66,67; 2024 c 104 art 2 s 12,15; 2024 c 115 art 7 s 2; 2024 c 127 art 54 s 6,7; art 55 s 8-10; art 57 s 56-64; art 60 s 21-23; art 61 s 21; 2025 c 20 s 208; 1Sp2025 c 3 art 1 s 85,86; art 3 s 123; art 4 s 2-5; art 8 s 9-17; 1Sp2025 c 9 art 4 s 46,55; art 9 s 6; 2026 c 95 art 4 s 13; art 5 s 27,28; art 9 s 7; 2026 c 121 art 3 s 27-29; art 6 s 16; art 7 s 48; art 10 s 1,2; 2026 c 127 art 5 s 8

NOTE: The amendment to subdivision 2 by Laws 2025, First Special Session chapter 3, article 1, section 85, is effective upon federal approval. The commissioners of health and human services shall inform the revisor of statutes when federal approval is obtained. Laws 2025, First Special Session chapter 3, article 1, section 85, the effective date.

NOTE: Subdivision 2b, as added by Laws 2025, First Special Session chapter 3, article 1, section 86, is effective upon federal approval. The commissioners of health and human services shall inform the revisor of statutes when federal approval is obtained. Laws 2025, First Special Session chapter 3, article 1, section 86, the effective date.

NOTE: The amendment to subdivision 3b by Laws 2025, First Special Session chapter 3, article 8, section 9, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2025, First Special Session chapter 3, article 8, section 9, the effective date.

NOTE: The amendment to subdivision 4 by Laws 2026, chapter 95, article 9, section 7, is effective upon federal approval. Laws 2026, chapter 95, article 9, section 7, the effective date.

NOTE: The amendment to subdivision 5m by Laws 2023, chapter 70, article 18, section 21, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2023, chapter 70, article 18, section 21, the effective date.

NOTE: The amendment to subdivision 5m by Laws 2025, First Special Session chapter 9, article 4, section 46, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2025, First Special Session chapter 9, article 4, section 46, the effective date.

NOTE: The amendment to subdivision 5m by Laws 2026, chapter 121, article 7, section 48, is effective January 1, 2028. Laws 2026, chapter 121, article 7, section 56.

NOTE: The amendments to subdivisions 8, 8a, 8e, and 54 by Laws 2025, First Special Session chapter 3, article 8, sections 10 to 12 and 16, are effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2025, First Special Session chapter 3, article 8, sections 10 to 12 and 16, the effective dates.

NOTE: The amendment to subdivision 10 by Laws 2024, chapter 127, article 60, section 21, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2024, chapter 127, article 60, section 21, the effective date.

NOTE: The amendment to subdivision 13 by Laws 2025, First Special Session chapter 3, article 4, section 2, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2025, First Special Session chapter 3, article 4, section 2, the effective date.

NOTE: The amendment to subdivision 13e by Laws 2025, First Special Session chapter 3, article 4, section 5, is effective upon federal approval. The commissioner of human services must notify the revisor of statutes when federal approval is obtained. Laws 2025, First Special Session chapter 3, article 4, section 5, the effective date.

NOTE: The amendment to subdivision 13k by Laws 2024, chapter 127, article 54, section 7, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2024, chapter 127, article 54, section 7, the effective date.

NOTE: The amendment to subdivision 17 by Laws 2023, chapter 61, article 3, section 5, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2023, chapter 61, article 3, section 5, the effective date.

NOTE: Subdivisions 18b, 18e, and 18h are repealed by Laws 2025, First Special Session chapter 3, article 8, section 43, effective upon implementation of the administrator under subdivision 18i. Laws 2025, First Special Session chapter 3, article 8, section 43, the effective date, as amended by Laws 2026, chapter 121, article 3, section 62.

NOTE: The amendment to subdivision 26 by Laws 2024, chapter 115, article 7, section 2, is effective upon federal approval. Laws 2024, chapter 115, article 7, section 2, the effective date.

NOTE: The amendment to subdivision 30 by Laws 2023, chapter 70, article 1, section 20, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2023, chapter 70, article 1, section 20, the effective date.

NOTE: The amendment to subdivision 31 by Laws 2023, chapter 70, article 1, section 21, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2023, chapter 70, article 1, section 21, the effective date.

NOTE: Subdivision 38 is repealed by Laws 2025, First Special Session chapter 3, article 8, section 43, effective on the latest of the following: (1) federal approval of the repeal of this subdivision; (2) federal approval of the amendment to Minnesota Statutes, section 256B.76, subdivision 6, by Laws 2025, First Special Section chapter 3, article 8, section 28; (3) federal approval of the amendments to Minnesota Statutes, section 256B.761, by Laws 2025, First Special Session chapter 3, article 8, section 29; or (4) federal approval of all necessary federal waivers to implement the managed care organization assessment in Minnesota Statutes, section 256B.1976. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2025, First Special Session chapter 3, article 8, section 43, the effective date.

NOTE: Subdivision 39, paragraph (b), as added by Laws 2024, chapter 127, article 60, section 23, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2024, chapter 127, article 60, section 23, the effective date.

NOTE: Subdivision 53, as added by Laws 2009, chapter 173, article 3, section 10, is effective upon federal approval. Laws 2009, chapter 173, article 3, section 10, the effective date.

NOTE: Subdivision 54a, as added by Laws 2025, First Special Session chapter 3, article 8, section 17, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2025, First Special Session chapter 3, article 8, section 17, the effective date.

NOTE: The amendment to subdivision 56a by Laws 2022, chapter 99, article 1, section 16, is effective upon federal approval. Laws 2022, chapter 99, article 1, section 16, the effective date.

NOTE: Subdivision 69, as added by Laws 2023, chapter 70, article 1, section 24, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2023, chapter 70, article 1, section 24, the effective date.

NOTE: Subdivision 72, as added by Laws 2024, chapter 127, article 57, section 60, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

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

(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. MS 1990 [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]

[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. MS 2004 [Repealed, 2005 c 98 art 2 s 18]

Subd. 2. MS 2004 [Repealed, 2005 c 98 art 2 s 18]

Subd. 3. MS 1996 [Repealed, 1997 c 7 art 2 s 67]

Subd. 4. MS 2004 [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*

256B.0631 PROHIBITION ON COST-SHARING.

Subdivision 1. MS 2023 Supp [Repealed, 2023 c 70 art 16 s 23]

Subd. 1a. **Prohibition on cost-sharing and deductibles.** Except for recipients eligible under section 256B.055, subdivision 15, the medical assistance benefit plan must not include cost-sharing or deductibles for any medical assistance recipient or benefit.

Subd. 2. MS 2022 [Repealed, 2023 c 70 art 16 s 23]

Subd. 3. MS 2023 Supp [Repealed, 2023 c 70 art 16 s 23]

Subd. 4. MS 2006 [Repealed, 2007 c 147 art 5 s 41]

Subd. 5. **Cost sharing.** (a) Effective for services provided on or after October 1, 2028, except as provided in subdivision 6, the medical assistance benefit plan includes the following cost sharing for recipients eligible under section 256B.055, subdivision 15, with income above 100 percent of the federal poverty level:

(1) $3 per nonpreventive visit, except as provided in paragraph (c). For purposes of this subdivision, a visit means an episode of service that is required because of a recipient's symptoms, diagnosis, or established illness, and that is delivered in an ambulatory setting by a physician or physician assistant, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

(2) $3.50 for nonemergency visits to a hospital-based emergency room; and

(3) $3 per brand-name drug prescription, $1 per generic drug prescription, and $1 per prescription for a brand-name multisource drug listed in preferred status on the preferred drug list, subject to a $12 maximum per month for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness.

(b) Cost sharing for prescription drugs and related medical supplies to treat chronic disease must comply with the requirements of section 62Q.481.

(c) A person eligible for medical assistance under section 256B.055, subdivision 15, is responsible for all co-payments and deductibles in this subdivision.

Subd. 6. **Exceptions.** Co-payments and deductibles are subject to the exceptions and limits required by Public Law 119-21, section 71120.

Subd. 7. **Collection.** (a) The medical assistance reimbursement to the provider must be reduced by the amount of the co-payment or deductible, except that reimbursements must not be reduced:

(1) once a recipient has reached the $12 maximum per month for prescription drug co-payments; or

(2) for a recipient who has met the recipient's monthly five percent cost-sharing limit.

(b) The provider collects the co-payment or deductible from the recipient. Providers must not deny services to recipients who are unable to pay the co-payment or deductible.

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; 2015 c 71 art 11 s 29; 2016 c 125 s 15; 1Sp2021 c 7 art 1 s 17; 2023 c 57 art 2 s 61; 2023 c 70 art 16 s 12-14,23; 2026 c 127 art 6 s 15-18*

256B.0632 INTENSIVE RESIDENTIAL TREATMENT SERVICES.

Subdivision 1. **Scope.** (a) Subject to federal approval, medical assistance covers medically necessary, intensive residential treatment services when the services are provided by an entity licensed under and meeting the standards in section 245I.23.

(b) The provider entity must make reasonable and good faith efforts to report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner.

Subd. 2. **Provider entity licensure and contract requirements for intensive residential treatment services.** (a) The commissioner shall develop procedures for counties and providers to submit other documentation as needed to allow the commissioner to determine whether the standards in this section are met.

(b) A provider entity must specify in the provider entity's application what geographic area and populations will be served by the proposed program. A provider entity must document that the capacity or program specialties of existing programs are not sufficient to meet the service needs of the target population. A provider entity must submit evidence of ongoing relationships with other providers and levels of care to facilitate referrals to and from the proposed program.

(c) A provider entity must submit documentation that the provider entity requested a statement of need from each county board and Tribal authority that serves as a local mental health authority in the proposed service area. The statement of need must specify if the local mental health authority supports or does not support the need for the proposed program and the basis for this determination. If a local mental health authority does not respond within 60 days of the receipt of the request, the commissioner shall determine the need for the program based on the documentation submitted by the provider entity.

Subd. 3. **Medical assistance payment for intensive residential treatment services.** (a) Payment for intensive residential treatment services in this section shall be based on one daily rate per provider inclusive of the following services received by an eligible client 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 (d), payment will 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 must determine how to distribute the payment among the members.

(c) Payment must not be made based solely on a court order to participate in intensive residential treatment services. If a client has a court order to participate in the program or to obtain assessment for treatment and follow treatment recommendations, payment under this section must only be provided if the client is eligible for the service and the service is determined to be medically necessary.

(d) The commissioner shall determine one rate for each provider that will bill medical assistance for intensive residential treatment services under this section. If a single entity provides both intensive residential treatment services under this section and assertive community treatment under section 256B.0622, one rate is established for the entity's intensive residential treatment services under this section and another rate for the entity's assertive community treatment services under section 256B.0622. 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 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) physical plant costs calculated based on the percentage of space within the program that is entirely devoted to treatment and programming. This does not include administrative or residential space; and

(iv) subject to federal approval, up to an additional five percent of the total rate may be added to the program rate as a quality incentive based upon the entity meeting performance criteria specified by the commissioner;

(2) actual costs are 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 Uniform Guidance under Code of Federal Regulations, title 2, section 200, relating to nonprofit entities;

(3) the number of services units;

(4) the degree to which clients will receive services other than services under this section or section 256B.0622; and

(5) the costs of other services that will be separately reimbursed.

(e) The rate for intensive residential treatment services must exclude the medical assistance room and board rate, as defined in section 256B.056, subdivision 5d, and services not covered under this section, such as partial hospitalization, home care, and inpatient services.

(f) Physician services that are not separately billed may be included in the rate to the extent that a psychiatrist, or other health care professional providing physician services within their scope of practice, is a member of the intensive residential treatment services treatment team. Physician services, whether billed separately or included in the rate, may be delivered by telehealth. For purposes of this paragraph, "telehealth" has the meaning given to "mental health telehealth" in section 256B.0625, subdivision 46, when telehealth is used to provide intensive residential treatment services.

(g) The rate for a provider must not exceed the rate charged by that provider for the same service to other payors.

(h) 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 (d). The rates for new programs must be established based upon estimated expenditures and estimated utilization using the criteria established in paragraph (d).

(i) Effective upon the expiration of section 256B.0622, subdivision 8, paragraph (i), and effective for rate years beginning on and after January 1, 2024, rates for intensive residential treatment services and adult residential crisis stabilization services must be annually adjusted for inflation using the Centers for Medicare and Medicaid Services Medicare Economic Index, as forecasted in the third quarter of the calendar year

before the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined.

(j) 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 and must reflect a difference of greater than five percent.

(k) A provider may request of the commissioner a review of any rate-setting decision made under this subdivision.

Subd. 4. **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.

Subd. 5. **Provider enrollment; rate setting for specialized program.** A county contract is not required for a provider proposing to serve a subpopulation of eligible clients 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.

Subd. 6. **Sustainability grants.** The commissioner may disburse grant funds directly to intensive residential treatment services providers to maintain access to these services.

Subd. 7. **Start-up grants.** The commissioner may, within available appropriations, disburse grant funding to counties, Indian Tribes, or mental health service providers to establish additional intensive residential treatment services and residential crisis services.

History: *2025 c 38 art 6 s 5*

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 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. MS 2000 [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:

(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 or MinnesotaCare.

History: *2007 c 147 art 12 s 11; 2016 c 158 art 2 s 90*

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.0638 OPIOID PRESCRIBING IMPROVEMENT PROGRAM.

Subdivision 1. **Program established.** The commissioner of human services, in conjunction with the commissioner of health, shall coordinate and implement an opioid prescribing improvement program to reduce opioid dependency and substance use by Minnesotans due to the prescribing of opioid analgesics by health care providers and to support patient-centered, compassionate care for Minnesotans who require treatment with opioid analgesics.

Subd. 2. **Definitions.** (a) For purposes of this section, the terms defined in this subdivision have the meanings given them.

(b) "Commissioner" means the commissioner of human services.

(c) "Commissioners" means the commissioner of human services and the commissioner of health.

(d) "DEA" means the United States Drug Enforcement Administration.

(e) "Minnesota health care program" means a public health care program administered by the commissioner of human services under this chapter and chapter 256L, and the Minnesota restricted recipient program.

(f) "Opioid disenrollment standards" means parameters of opioid prescribing practices that fall outside community standard thresholds for prescribing to such a degree that a provider must be disenrolled as a Minnesota health care program provider.

(g) "Opioid prescriber" means a licensed health care provider who prescribes opioids to Minnesota health care program and MinnesotaCare enrollees under the fee-for-service system or under a managed care or county-based purchasing plan.

(h) "Opioid quality improvement standard thresholds" means parameters of opioid prescribing practices that fall outside community standards for prescribing to such a degree that quality improvement is required.

(i) "Program" means the statewide opioid prescribing improvement program established under this section.

(j) "Provider group" means a clinic, hospital, or primary or specialty practice group that employs, contracts with, or is affiliated with an opioid prescriber. Provider group does not include a professional association supported by dues-paying members.

(k) "Sentinel measures" means measures of opioid use that identify variations in prescribing practices during the prescribing intervals.

Subd. 3. **Opioid prescribing work group.** (a) The commissioner of human services, in consultation with the commissioner of health, shall appoint the following voting members to an opioid prescribing work group:

(1) two consumer members who have been impacted by an opioid abuse disorder or opioid dependence disorder, either personally or with family members;

(2) one member who is a licensed physician actively practicing in Minnesota and registered as a practitioner with the DEA;

(3) one member who is a licensed pharmacist actively practicing in Minnesota and registered as a practitioner with the DEA;

(4) one member who is a licensed advanced practice registered nurse actively practicing in Minnesota and registered as a practitioner with the DEA;

(5) one member who is a licensed dentist actively practicing in Minnesota and registered as a practitioner with the DEA;

(6) two members who are nonphysician licensed health care professionals actively engaged in the practice of their profession in Minnesota, and their practice includes treating pain;

(7) one member who is a mental health professional who is licensed or registered in a mental health profession, who is actively engaged in the practice of that profession in Minnesota, and whose practice includes treating patients with substance use disorder or substance abuse;

(8) one member who is a medical examiner for a Minnesota county;

(9) one member of the Health Services Advisory Council established under section 256B.0625, subdivisions 3c to 3e;

(10) one member who is a medical director of a health plan company doing business in Minnesota;

(11) one member who is a pharmacy director of a health plan company doing business in Minnesota;

(12) one member representing Minnesota law enforcement; and

(13) two consumer members who are Minnesota residents and who have used or are using opioids to manage chronic pain.

(b) In addition, the work group shall include the following nonvoting members:

(1) the medical director for the medical assistance program;

(2) a member representing the Department of Human Services pharmacy unit;

(3) the medical director for the Department of Labor and Industry; and

(4) a member representing the Minnesota Department of Health.

(c) An honorarium of $200 per meeting and reimbursement for mileage and parking shall be paid to each voting member in attendance.

Subd. 4. **Program components.** (a) The working group shall recommend to the commissioners the components of the statewide opioid prescribing improvement program, including, but not limited to, the following:

(1) developing criteria for opioid prescribing protocols, including:

(i) prescribing for the interval of up to four days immediately after an acute painful event;

(ii) prescribing for the interval of up to 45 days after an acute painful event; and

(iii) prescribing for chronic pain, which for purposes of this program means pain lasting longer than 45 days after an acute painful event;

(2) developing sentinel measures;

(3) developing educational resources for opioid prescribers about communicating with patients about pain management and the use of opioids to treat pain;

(4) developing opioid quality improvement standard thresholds and opioid disenrollment standards for opioid prescribers and provider groups. In developing opioid disenrollment standards, the standards may be described in terms of the length of time in which prescribing practices fall outside community standards and the nature and amount of opioid prescribing that fall outside community standards; and

(5) addressing other program issues as determined by the commissioners.

(b) The opioid prescribing protocols shall not apply to opioids prescribed for patients who are experiencing pain caused by a malignant condition or who are receiving hospice care or palliative care, or to opioids prescribed for substance use disorder treatment with medications for opioid use disorder.

(c) All opioid prescribers who prescribe opioids to Minnesota health care program enrollees must participate in the program in accordance with subdivision 5. Any other prescriber who prescribes opioids may comply with the components of this program described in paragraph (a) on a voluntary basis.

Subd. 5. **Program implementation.** (a) The commissioner shall implement the quality improvement program to improve the health of and quality of care provided to Minnesota health care program enrollees. The program must be designed to support patient-centered care consistent with community standards of care. The program must discourage unsafe tapering practices and patient abandonment by providers. The commissioner shall annually collect and report to provider groups the sentinel measures of data showing individual opioid prescribers' opioid prescribing patterns compared to their anonymized peers. Provider groups shall distribute data to their affiliated, contracted, or employed opioid prescribers.

(b) The commissioner shall notify an opioid prescriber and all provider groups with which the opioid prescriber is employed or affiliated when the opioid prescriber's prescribing pattern exceeds the opioid quality improvement standard thresholds. An opioid prescriber and any provider group that receives a notice under this paragraph shall submit to the commissioner a quality improvement plan for review and approval

by the commissioner with the goal of bringing the opioid prescriber's prescribing practices into alignment with community standards. A quality improvement plan must include:

(1) components of the program described in subdivision 4, paragraph (a);

(2) internal practice-based measures to review the prescribing practice of the opioid prescriber and, where appropriate, any other opioid prescribers employed by or affiliated with any of the provider groups with which the opioid prescriber is employed or affiliated; and

(3) demonstration of patient-centered care consistent with community standards of care.

(c) If, after a year from the commissioner's notice under paragraph (b), the opioid prescriber's prescribing practices for treatment of acute or postacute pain do not improve so that they are consistent with community standards, the commissioner may take one or more of the following steps:

(1) require the prescriber, the provider group, or both, to monitor prescribing practices more frequently than annually;

(2) monitor more aspects of the opioid prescriber's prescribing practices than the sentinel measures; or

(3) require the opioid prescriber to participate in additional quality improvement efforts.

(d) Prescribers treating patients who are on chronic, high doses of opioids must meet community standards of care, including performing regular assessments and addressing unwarranted risks of opioid prescribing, but are not required to show measurable changes in chronic pain prescribing thresholds within a certain period.

(e) The commissioner shall dismiss a prescriber from participating in the opioid prescribing quality improvement program on an annual basis when the prescriber demonstrates that the prescriber's practices are patient-centered and reflect community standards for safe and compassionate treatment of patients experiencing pain.

(f) The commissioner may investigate for possible disenrollment all opioid prescribers and provider groups whose prescribing practices fall within the applicable opioid disenrollment standards.

(g) No physician, advanced practice registered nurse, or physician assistant, acting in good faith based on the needs of the patient, may be disenrolled by the commissioner of human services solely for prescribing a dosage that equates to an upward deviation from morphine milligram equivalent dosage recommendations specified in state or federal opioid prescribing guidelines or policies, or quality improvement thresholds established under this section.

Subd. 6. **Data practices.** (a) Reports and data identifying an opioid prescriber are private data on individuals as defined under section 13.02, subdivision 12, until an opioid prescriber is subject to termination as a medical assistance provider under this section. Notwithstanding this data classification, the commissioner shall share with all of the provider groups with which an opioid prescriber is employed, contracted, or affiliated, the data under subdivision 5, paragraph (a), (b), or (c).

(b) Reports and data identifying a provider group are nonpublic data as defined under section 13.02, subdivision 9, until the provider group is subject to termination as a medical assistance provider under this section.

(c) Upon termination under this section, reports and data identifying an opioid prescriber or provider group are public, except that any identifying information of Minnesota health care program enrollees must be redacted by the commissioner.

Subd. 6a. **Waiver for certain provider groups.** (a) This section does not apply to prescribers employed by, or under contract or affiliated with, a provider group for which the commissioner has granted a waiver from the requirements of this section.

(b) The commissioner, in consultation with opioid prescribers, shall develop waiver criteria for provider groups, and shall make waivers available beginning July 1, 2023. In granting waivers, the commissioner shall consider whether the medical director of the provider group and a majority of the practitioners within a provider group have specialty training, fellowship training, or experience in treating chronic pain. Waivers under this subdivision must be granted on an annual basis.

Subd. 7. MS 2020 [Repealed, 2022 c 98 art 14 s 33]

History: *2015 c 71 art 11 s 30; 2021 c 30 art 1 s 12-14,24; 2022 c 58 s 170; 2022 c 98 art 2 s 10; art 4 s 51; art 6 s 25; 2023 c 61 art 6 s 1-5*

256B.064 SANCTIONS; MONETARY RECOVERY.

Subdivision 1. **Terminating payments to ineligible individuals or entities.** 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.** (a) The commissioner may impose sanctions against any individual or entity that receives payments from medical assistance or provides goods or services for which payment is made from medical assistance for any of the following:

(1) fraud, theft, or abuse in connection with the provision of goods and services to recipients of public assistance for which payment is made from medical 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 individual or entity 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 an individual or entity could be excluded from participation in the Medicare program under section 1128, 1128A, or 1866(b)(2) of the Social Security Act.

(b) For the purposes of this section, goods or services for which payment is made from medical assistance includes but is not limited to care and services identified in section 256B.0625 or provided pursuant to any federally approved waiver.

(c) Regardless of the source of payment or other item of value, the commissioner may impose sanctions against any individual or entity that solicits, receives, pays, or offers to pay any illegal remuneration as described in section 142E.51, subdivision 6a, in violation of section 609.542, subdivision 2, or in violation of United States Code, title 42, section 1320a-7b(b)(1) or (2). No conviction is required before the commissioner can impose sanctions under this paragraph.

(d) The commissioner may impose sanctions against a pharmacy provider for failure to respond to a cost of dispensing survey under section 256B.0625, subdivision 13e, paragraph (g).

(e) The commissioner may impose sanctions against a pharmacy provider for failure to respond to a Minnesota drug acquisition cost survey under section 256B.0625, subdivision 13e, paragraph (i).

[See Note.]

Subd. 1b. **Sanctions available.** (a) The commissioner may impose the following sanctions for the conduct described in subdivision 1a:

(1) suspending payments to an individual or entity;

(2) temporarily withholding payments to an individual or entity;

(3) suspending participation in the program;

(4) terminating participation in the program; or

(5) imposing a fine under subdivision 2a.

(b) When imposing sanctions under this section, the commissioner must 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 individual or entity.

(c) The commissioner must suspend an individual's or entity's participation in the program for a minimum of five years if the individual or entity is convicted of a crime, received a stay of adjudication, or entered a court-ordered diversion program for an offense related to a provision of a health service under medical assistance, including a federally approved waiver, or health care fraud.

(d) 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 an individual or entity that has been improperly paid by the department either as a result of conduct described in subdivision 1a or as a result of an error by the individual or entity submitting the claim or by the department, 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 must 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 must be the rate established by the commissioner of revenue under section 270C.40.

Subd. 1d. **Investigative costs.** (a) The commissioner may seek recovery of investigative costs from any individual or entity that willfully submits a claim for reimbursement for services that the individual or entity knows, or reasonably should have known, is a false representation and that results in the payment of public funds for which the individual or entity is ineligible.

(b) Billing errors that result in unintentional overcharges are not grounds for investigative cost recoupment.

Subd. 2. **Imposition of monetary recovery and sanctions; generally.** (a) The commissioner must determine any monetary amounts to be recovered and sanctions to be imposed upon an individual or entity under this section. Except as provided in subdivision 2c, the commissioner must not obtain a monetary recovery or impose a sanction 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 an individual or entity, 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) Upon receipt of a notice under paragraph (a) that a monetary recovery or sanction is to be imposed, an individual or entity 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 individual or entity. 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 individual or entity believes is correct;

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

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

(5) other information required by the commissioner.

Subd. 2a. **Imposition of fines.** (a) The commissioner may order an individual or entity 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 equals 20 percent of the amount paid on the claims for reimbursement submitted by the individual or entity, or up to $5,000, whichever is less.

(b) If the commissioner determines that an individual or entity repeatedly violated this chapter, chapter 245G or 254B, or Minnesota Rules, chapter 9505, related to the provision of services to program recipients and the submission of claims for payment, the commissioner may order an individual or entity to forfeit a fine based on the nature, severity, and chronicity of the violations, in an amount of up to $5,000 or 20 percent of the value of the claims, whichever is greater.

(c) The individual or entity must pay the fine assessed on or before the payment date specified by the commissioner. If the individual or entity fails to pay the fine, the commissioner may withhold or reduce payments and recover the amount of the fine.

(d) A timely appeal stays payment of the fine until the commissioner issues a final order.

Subd. 2b. **Mandatory suspension or termination after exclusion from participation in Medicare.** (a) The commissioner must suspend or terminate an individual's or entity'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 individual's or entity's exclusion from participation in Medicare.

(b) Within five days of taking an action under paragraph (a), the commissioner must send notice of the suspension or termination to the individual or entity. The notice must:

(1) state that the suspension or termination is the result of the individual's or entity's exclusion from Medicare;

(2) identify the effective date of the suspension or termination; and

(3) inform the individual or entity of the need to be reinstated to Medicare before reapplying for participation in the program.

Subd. 2c. **Imposition of withholding or reduction of payments without prior notice.** (a) 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 must temporarily withhold or reduce payments to an individual or entity without providing advance notice of the withholding or reduction if either of the following occurs:

(1) the individual or entity 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. Allegations are considered credible when the allegations have indicia of reliability and the commissioner has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.

(b) A credible allegation of fraud is an allegation that has been verified by the state from any source, including but not limited to:

(1) fraud hotline complaints;

(2) claims data mining;

(3) patterns identified through provider audits, civil false claims cases, and law enforcement investigations; and

(4) court filings and other legal documents, including but not limited to police reports, complaints, indictments, informations, affidavits, declarations, and search warrants.

(c) The commissioner must send notice of the withholding or reduction of payments under paragraph (a) within five days of withholding or reducing payments unless requested in writing by a law enforcement agency to temporarily withhold the notice. The notice must:

(1) state that payments are being withheld or reduced according to paragraph (a);

(2) set forth the allegations as to the nature of the withholding or reduction in a manner reasonably calculated to provide notice, which must include but is not limited to date ranges of suspected claims, locations of suspected service delivery, and general nature of individual or entity conduct, but need not disclose specific information that the commissioner determines is likely to jeopardize an ongoing investigation;

(3) except in the case of a conviction for conduct described in subdivision 1a, state that the withholding or reduction is for a temporary period and cite the circumstances under which withholding or reduction will be terminated;

(4) identify the types of claims to which the withholding or reduction applies; and

(5) inform the individual or entity of the right to submit written evidence for consideration by the commissioner.

(d) The commissioner must immediately cease to withhold or reduce payments under this subdivision and must release the withheld or reduced payments no later than ten days following the earlier of the commissioner's determination that there is insufficient evidence of fraud by the individual or entity, or legal proceedings relating to the alleged fraud are completed, unless the commissioner has sent notice of intention to impose monetary recovery or sanctions.

Subd. 2d. **Administrative review of temporary payment withhold or reduction.** (a) Upon receipt of a notice under subdivision 2c, paragraph (c), that a payment withhold or reduction is imposed, an individual or entity may request a review under paragraph (c) by filing with the commissioner a written request for an administrative review. The review request must be received by the commissioner no later than 30 days after the date the notification of the payment withhold or reduction was mailed to the individual or entity. The review request must specify the reason the payment withholding or reduction decision is in error and clearly request a review. The commissioner must refer the review request to the Court of Administrative Hearings within ten business days of receiving the review request.

(b) The costs for the review under paragraph (c) must be borne equally by both parties.

(c) The burden of proof upon review of a temporary withhold or reduction is limited to whether the commissioner can establish that there is a credible allegation of fraud as provided in subdivision 2c, paragraph (a), clause (2). The administrative law judge's recommendation to the commissioner must not make findings on the veracity of the underlying allegations of fraud, as the underlying investigation remains ongoing and underlying facts may be litigated in future administrative, civil, or criminal proceedings after the commissioner issues a final decision.

(d) To protect the integrity of the ongoing investigation, the commissioner must submit evidence to support the action to the administrative law judge under seal. The individual or entity may submit evidence to the administrative law judge that supports the position of the individual or entity that the payment withholding or reduction decision is in error. The administrative law judge must review the evidence in camera. The commissioner must not be subject to discovery by the individual or entity during the proceedings.

(e) The commissioner must provide notice to the individual or entity within ten business days of the administrative law judge's completed recommendation. The notice must state that the review process under this subdivision is complete and must include whether the administrative law judge found that the commissioner established there was a credible allegation of fraud.

(f) The administrative law judge's findings of facts, conclusions of law, and recommendation as to whether there is a credible allegation of fraud must not be used or considered for any other purpose, including impeachment, in any civil, criminal, administrative, or contractual proceeding. The administrative law judge's findings of facts, conclusions of law, and recommendation must not be held conclusive or binding or used as evidence in any separate or subsequent action in any other forum, be it contractual, administrative, or judicial, regardless of whether the action involves the same or related parties or involves the same facts.

Subd. 2e. **Withholding or reduction of payments; review.** If a payment withhold or reduction under subdivision 2c remains in effect after 90 days, the commissioner must submit evidence to an administrative law judge under seal for the administrative law judge to determine whether the commissioner or a law enforcement agency is actively pursuing an investigation under this section. The administrative law judge must review the evidence in camera and provide a recommendation to the commissioner regarding continuing the withholding or reduction. The recommendation of the administrative law judge is advisory and the commissioner's decision to continue a withholding is final and not subject to appeal or reduction. The review under this subdivision must occur every 90 days for each payment withhold or reduction that is in effect. The commissioner must provide a notice to the individual or entity subject to the payment withhold or reduction within ten business days of the completion of each review under this subdivision. The notice must include the administrative law judge's recommendation.

Subd. 2f. **Judicial review.** The administrative law judge's findings of facts, conclusions of law, and recommendations under subdivisions 2d and 2e are not subject to judicial review.

Subd. 2g. **Forfeiture of withheld payments upon criminal conviction.** Upon conviction of a crime related to the provision, management, or administration of a health service under medical assistance, a payment withheld pursuant to this section by the commissioner or a managed care organization that contracts with the commissioner under section 256B.035 is forfeited to the commissioner or managed care organization, regardless of the amount charged in the criminal complaint or the amount of criminal restitution ordered.

Subd. 3. **Mandates on prohibited payments.** (a) The commissioner must maintain and publish a list of each excluded individual and entity that was convicted of a crime related to the provision, management, or administration of a medical assistance health service, or suspended or terminated under this section. Medical assistance payments cannot be made by an individual or entity for items or services furnished either directly or indirectly by an excluded individual or entity, or at the direction of excluded individuals or entities.

(b) The entity must check the exclusion list on a monthly basis and document the date and time the exclusion list was checked and the name and title of the person who checked the exclusion list. The entity must immediately terminate payments to an individual or entity on the exclusion list.

(c) An entity's requirement to check the exclusion list and to terminate payments to individuals or entities on the exclusion list applies to each individual or entity on the exclusion list, even if the named individual or entity is not responsible for direct patient care or direct submission of a claim to medical assistance.

(d) An entity that pays medical assistance program funds to an individual or entity on the exclusion list must refund any payment related to either items or services rendered by an individual or entity on the exclusion list from the date the individual or entity is first paid or the date the individual or entity is placed on the exclusion list, whichever is later, and an entity may be subject to:

(1) sanctions under this section;

(2) a civil monetary penalty of up to $25,000 for each determination by the department that the vendor employed or contracted with an individual or entity on the exclusion list; and

(3) other fines or penalties allowed by law.

Subd. 4. **Notice.** (a) The department must serve the notice required under this section using a signature-verified confirmed delivery method to the address submitted to the department by the individual or entity. Service is complete upon mailing.

(b) The department must give notice in writing to a recipient placed in the Minnesota restricted recipient program under section 256B.0646 and Minnesota Rules, part 9505.2200. The department must send the notice by first class mail to the recipient's current address on file with the department. A recipient placed in the Minnesota restricted recipient program may contest the placement by submitting a written request for a hearing to the department within 90 days of the notice being mailed.

Subd. 5. **Immunity; good faith reporters.** (a) A person who makes a good faith report is immune from any civil or criminal liability that might otherwise arise from reporting or participating in the investigation. Nothing in this subdivision affects an individual's or entity's responsibility for an overpayment established under this subdivision.

(b) A person employed by a lead investigative agency who is conducting or supervising an investigation or enforcing the law according to the applicable law or rule is immune from any civil or criminal liability that might otherwise arise from the person's actions, if the person is acting in good faith and exercising due care.

(c) For purposes of this subdivision, "person" includes a natural person or any form of a business or legal entity.

(d) After an investigation is complete, the reporter's name must be kept confidential. The subject of the report may compel disclosure of the reporter's name only with the consent of the reporter or upon a written finding by a district court that the report was false and there is evidence that the report was made in bad faith. This subdivision does not alter disclosure responsibilities or obligations under the Rules of Criminal Procedure, except that when the identity of the reporter is relevant to a criminal prosecution the district court must conduct an in-camera review before determining whether to order disclosure of the reporter's identity.

Subd. 6. **Application.** This section supersedes any inconsistent or contrary provision of law.

Subd. 7. **Coordination with law enforcement.** When a temporary withholding or reduction of payments under subdivision 2c involves potential criminal conduct, the commissioner must coordinate with appropriate law enforcement authorities, including the Minnesota attorney general's Medicaid Fraud Control Unit, and may consult with state or federal investigative agencies as necessary.

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; 1Sp2019 c 9 art 2 s 113-117; art 7 s 32; 1Sp2020 c 2 art 5 s 39; 2023 c 70 art 17 s 44; 2024 c 127 art 62 s 40; 2025 c 38 art 5 s 28; 1Sp2025 c 3 art 4 s 6; 2026 c 121 art 3 s 30-45*

NOTE: The amendment to subdivision 1a by Laws 2025, First Special Session chapter 3, article 4, section 6, is effective upon federal approval. The commissioner of human services must notify the revisor of statutes when federal approval is obtained. Laws 2025, First Special Session chapter 3, article 4, section 6, the effective date.

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.

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.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; 2015 c 74 s 7*

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 not be applicable in geographic areas where provider participation is limited by managed care contracts with the Department of Human Services. This section does not apply to dental service providers providing dental services outside the seven-county metropolitan area.

(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 providing dental services in the seven-county metropolitan area, 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; 1Sp2017 c 6 art 4 s 38*

256B.0645 MS 2014 [Repealed, 2016 c 158 art 2 s 123]

256B.0646 MINNESOTA RESTRICTED RECIPIENT PROGRAM; PERSONAL CARE ASSISTANCE SERVICES.

(a) When a recipient's use of personal care assistance services or community first services and supports under section 256B.85 results in abusive or fraudulent billing, the commissioner may place a recipient in the Minnesota restricted recipient program under Minnesota Rules, part 9505.2165. A recipient placed in the Minnesota restricted recipient program under this section must: (1) use a designated traditional personal care assistance provider agency; and (2) obtain a new assessment under section 256B.0911, including consultation with a registered or public health nurse on the long-term care consultation team pursuant to section 256B.0911, subdivision 15, paragraph (b), clause (2).

(b) A recipient must comply with additional conditions for the use of personal care assistance services or community first services and supports if the commissioner determines it is necessary to prevent future misuse of personal care assistance services or abusive or fraudulent billing. Additional conditions may include but are not limited to restricting service authorizations for a duration of no more than one month and requiring a qualified professional to monitor and report services on a monthly basis.

(c) A recipient placed in the Minnesota restricted recipient program under this section may appeal the placement according to section 256.045.

History: *1Sp2019 c 9 art 2 s 118; 2022 c 98 art 17 s 9*

256B.0647 REMITTANCE ADVICE MONETARY RECOVERY.

(a) The commissioner may use the remittance advice process under Code of Federal Regulations, title 45, part 162.1601, as the notice to a vendor or provider when seeking monetary recovery using a department-administered information technology system for programmatically processed claims. The remittance advice must be delivered electronically and constitutes the sole notice to the provider. The commissioner must withhold the payments at issue when using the remittance advice as the notice.

(b) Providers may seek reconsideration of a remittance under this section by mailing a request to the commissioner. The reconsideration request must be received no later than 30 calendar days from the posting of the remittance advice. A request for reconsideration does not stay the withholding of payments. The

commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14. The request for reconsideration must include:

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

(2) the calculation that the individual or entity believes is correct;

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

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

(5) other information required by the commissioner.

(c) The commissioner may not use the remittance advice process as notice required under section 256B.064.

History: *2026 c 121 art 3 s 46*

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

(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. MS 2008 [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. MS 2008 [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, 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.** Providers of home care services must meet the recipient protection requirements under section 256B.045 when subject to an administrative action or a serious operational event as defined in section 256B.045, subdivision 1.

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; 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; 1Sp2019 c 9 art 2 s 119; 2026 c 121 art 1 s 3

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 website:

(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;

(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 and community first services and supports as defined in section 256B.85 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.

(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.

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, assessment under sections 142A.607 and 260C.4411, 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 six, unless all conditions for a variance under section 142B.10, subdivision 17, are satisfied for a sibling, as defined in section 260C.007, subdivision 32.

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;

(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;

(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: *1986 c 444; 1990 c 568 art 3 s 51; 1991 c 292 art 7 s 12,13,25; 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 51-54; 1995 c 207 art 3 s 18; art 6 s 52-56; 1996 c 451 art 2 s 21; 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 8-11; 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; 1Sp2020 c 2 art 5 s 40; 2023 c 70 art 15 s 2; 2024 c 80 art 1 s 96; art 2 s 74; 2024 c 115 art 16 s 34,41*

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 by a home health agency to a recipient with medical needs due to illness, disability, or physical conditions in settings permitted under section 256B.0625, subdivision 6a.

(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.

(h) "Respiratory therapy services" mean the services defined in chapter 147C.

(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 may be provided in the recipient's home or in the community where normal life activities take the recipient.

(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, advanced practice registered nurse, or physician assistant and documented in a plan of care that is reviewed and approved by the ordering practitioner at least once every 60 days. All skilled nurse visits must be medically necessary and provided in the recipient's home residence or in the community where normal life activities take the recipient, 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 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 or in the community where normal life activities take the recipient after it has been determined the recipient is unable to access outpatient therapy;

(2) prescribed, ordered, or referred by a physician, advanced practice registered nurse, or physician assistant, 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

(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;

(4) home care therapies provided in other settings such as a clinic or as an inpatient or when the recipient can access therapy outside of the recipient's residence; and

(5) home health agency services without qualifying documentation of a face-to-face encounter as specified in subdivision 7.

Subd. 7. **Face-to-face encounter.** (a) A face-to-face encounter by a qualifying provider must be completed for all home health services regardless of the need for prior authorization, except when providing a onetime perinatal visit by skilled nursing. The face-to-face encounter may occur through telehealth as defined in section 256B.0625, subdivision 3b. The encounter must be related to the primary reason the recipient requires home health services and must occur within the 90 days before or the 30 days after the start of services. The face-to-face encounter may be conducted by one of the following practitioners, licensed in Minnesota:

(1) a physician;

(2) an advanced practice registered nurse; or

(3) a physician assistant.

(b) The allowed practitioner, as described in this subdivision, performing the face-to-face encounter but who is not the ordering practitioner must communicate the clinical findings of that face-to-face encounter to the ordering practitioner. The clinical findings of that face-to-face encounter must be incorporated into a written or electronic document included in the recipient's medical record. To assure clinical correlation between the face-to-face encounter and the associated home health services, the practitioner responsible for ordering the services must:

(1) document that the face-to-face encounter, which is related to the primary reason the recipient requires home health services, occurred within the required time period; and

(2) indicate the practitioner who conducted the encounter and the date of the encounter.

(c) For home health services requiring authorization, including prior authorization, home health agencies must retain the qualifying documentation of a face-to-face encounter as part of the recipient health service record, and submit the qualifying documentation to the commissioner or the commissioner's designee upon request.

Subd. 8. **Payment rates for home health agency services.** The commissioner shall annually adjust payments for home health agency services to reflect the change in the federal Centers for Medicare and Medicaid Services Home Health Agency Market Basket. The commissioner shall use the indices as forecasted for the midpoint of the prior rate year to the midpoint of the current rate year.

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; 2016 c 158 art 1 s 112; 2017 c 59 s 10; 1Sp2017 c 6 art 1 s 7-12; 1Sp2020 c 2 art 2 s 14-16; 1Sp2021 c 7 art 6 s 28; art 13 s 11*

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 hourly nursing ordered by a physician, advanced practice registered nurse, or physician assistant and 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:

(1) assessed by a registered nurse on a form approved by the commissioner;

(2) ordered by a physician, advanced practice registered nurse, or physician assistant and documented in a plan of care that is reviewed by the ordering practitioner 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 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 142B 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, advanced practice registered nurse, or physician assistant, 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

(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 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, advanced practice registered nurse, or physician assistant 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, advanced practice registered nurse, or physician assistant orders.

(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.

Subd. 5. **Payment rates for home care nursing services.** The commissioner shall annually adjust payments for home care nursing services to reflect the change in the federal Centers for Medicare and Medicaid Services Home Health Agency Market Basket. The commissioner shall use the indices as forecasted for the midpoint of the prior rate year to the midpoint of the current rate year.

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; 2015 c 21 art 1 s 56; 2020 c 115 art 4 s 121-124; 1Sp2020 c 2 art 2 s 17-20; 1Sp2021 c 7 art 13 s 12; 2024 c 80 art 2 s 74; 2024 c 115 art 16 s 41*

256B.0655 Subdivision 1. MS 2008 [Repealed, 2009 c 79 art 8 s 86]

Subd. 1a. MS 2008 [Repealed, 2009 c 79 art 8 s 86]

Subd. 1b. MS 2008 [Renumbered 256B.0659, subd 3a]

Subd. 1c. MS 2008 [Repealed, 2009 c 79 art 8 s 86]

Subd. 1d. MS 2008 [Repealed, 2009 c 79 art 8 s 86]

Subd. 1e. MS 2008 [Repealed, 2009 c 79 art 8 s 86]

Subd. 1f. MS 2008 [Repealed, 2009 c 79 art 8 s 86]

Subd. 1g. MS 2008 [Repealed, 2009 c 79 art 8 s 86]

Subd. 1h. MS 2008 [Repealed, 2009 c 79 art 8 s 86]

Subd. 1i. MS 2008 [Repealed, 2009 c 79 art 8 s 86]

Subd. 2. MS 2008 [Repealed, 2009 c 79 art 8 s 86]

Subd. 3. MS 2008 [Repealed, 2009 c 79 art 8 s 86]

Subd. 4. MS 2008 [Renumbered 256B.0652, subd 6]

Subd. 5. MS 2008 [Repealed, 2009 c 79 art 8 s 86]

Subd. 6. MS 2008 [Repealed, 2009 c 79 art 8 s 86]

Subd. 7. MS 2008 [Repealed, 2009 c 79 art 8 s 86]

Subd. 8. MS 2008 [Repealed, 2009 c 79 art 8 s 86]

Subd. 9. MS 2008 [Repealed, 2009 c 79 art 8 s 86]

Subd. 10. MS 2008 [Repealed, 2009 c 79 art 8 s 86]

Subd. 11. MS 2008 [Repealed, 2009 c 79 art 8 s 86]

Subd. 12. MS 2008 [Repealed, 2009 c 79 art 8 s 86]

Subd. 13. MS 2008 [Repealed, 2009 c 79 art 8 s 86]

256B.0656 MS 2012 [Repealed, 2014 c 262 art 4 s 9]

256B.0657 MS 2012 [Repealed, 2014 c 262 art 4 s 9]

256B.0658 HOUSING ACCESS GRANTS.

Subdivision 1. **Establishment.** The commissioner of human services shall award through a competitive process contracts for grants to public and private agencies to support and assist individuals with a disability to access housing.

Subd. 2. **Definition.** (a) For the purposes of this section, the term defined in this subdivision has the meaning given.

(b) "Individual with a disability" means:

(1) an individual who is aged, blind, or disabled as determined by the criteria under sections 216(i)(1) and 221 of the Social Security Act; or

(2) an individual who meets a category of eligibility under section 256D.05, subdivision 1, paragraph (a), clause (1), (4), (5) to (8), or (13).

Subd. 3. **Allowable uses of grant money.** 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; 1Sp2019 c 9 art 5 s 34; 2026 c 88 art 1 s 124,225; 2026 c 95 art 4 s 14*

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 toward 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 chapter 256S and sections 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. For purposes of this

paragraph, traveling includes driving and accompanying the recipient in the recipient's chosen mode of transportation and according to the recipient's personal care assistance care plan.

(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;

(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, advanced practice registered nurse, licensed respiratory therapist, physician assistant, or 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.

(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 determining a person's eligibility for home and community-based waiver services including personal care assistance services according to section 256B.0911. During the transition to MnCHOICES, a certified assessor may complete the assessment defined in this subdivision. 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 ongoing 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 18.

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, advanced practice registered nurse, or physician assistant; specified in a personal care assistance care plan or assessment summary 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:

(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, advanced practice registered nurse, or physician assistant 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:

(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 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, advanced practice registered nurse, or physician assistant.** The personal care assistance program requires communication with the recipient's physician, advanced practice registered nurse, or physician assistant 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, advanced practice registered nurse, or physician assistant.

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;

(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 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) 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, physician, advanced practice registered nurse, or physician assistant;

(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 310 hours per month of personal care assistance services regardless of the number of recipients being served or the number of personal care assistance 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.

(d) Personal care assistance services qualify for the enhanced rate described in subdivision 17a if the personal care assistant providing the services:

(1) provides covered services to a recipient who qualifies for ten or more hours per day of personal care assistance services; and

(2) satisfies the current requirements of Medicare for training and competency or competency evaluation of home health aides or nursing assistants, as provided in the Code of Federal Regulations, title 42, section 483.151 or 484.36, or alternative state-approved training or competency requirements.

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 and either the recipient's medical assistance identification number or date of birth;

(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;

(6) personal signature of the personal care assistant;

(7) any shared services 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;

(9) dates and location of recipient stays in a hospital, care facility, or incarceration; and

(10) any time spent traveling, as described in subdivision 1, paragraph (i), including start and stop times with a.m. and p.m. designations, the origination site, and the destination site.

Subd. 13. **Qualified professional; qualifications.** (a) The qualified professional must work for a personal care assistance provider agency, meet the definition of qualified professional under section 256B.0625, subdivision 19c, clear a background study, and meet provider training requirements. 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) 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 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;

(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. 14a. **Qualified professional; remote supervision.** (a) For recipients with chronic health conditions or severely compromised immune systems, a qualified professional may conduct the supervision required under subdivision 14 via two-way interactive audio and visual telecommunication if, at the recipient's request, the recipient's primary health care provider:

(1) determines that remote supervision is appropriate; and

(2) documents the determination under clause (1) in a statement of need or other document that is subsequently included in the recipient's personal care assistance care plan.

(b) Notwithstanding any other provision of law, a care plan developed or amended via remote supervision may be executed by electronic signature.

(c) A personal care assistance provider agency must not conduct its first supervisory visit for a recipient or complete its initial personal care assistance care plan via a remote visit.

(d) A recipient may request to return to in-person supervisory visits at any time.

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 authorization 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 personal care assistance services that are shared services are limited according to this subdivision.

(b) For the purposes of this section, "shared services" means the provision of personal care assistance services by a personal care assistant to two or three recipients who are all eligible for medical assistance and who each 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 142B or operated by a local school district or private school.

(d) Shared services follow the same criteria for covered services as subdivision 2.

(e) Noncovered shared 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;

(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 services.

(f) The option of shared services 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 services 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 the recipients' 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 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 to all the recipients in a shared setting;

(2) visit the shared setting as shared 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 that 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.** (a) For the purposes of this subdivision, "additional revenue for shared services" means the difference between the rate paid to a personal care assistance provider agency for serving a single recipient and the sum of the rates paid to a personal care assistance provider agency for shared services provided to more than one recipient.

(b) For the purposes of this subdivision, "wages and wage-related costs" means increased wages and any corresponding increase in the employer's share of FICA taxes, Medicare taxes, state and federal

unemployment taxes, workers' compensation premiums, and contributions to employee retirement accounts if the contribution is a function of wages.

(c) The commissioner shall provide a rate system for shared services. For two recipients sharing services, the rate paid to a personal care assistance provider agency for the shared services must not exceed one and one-half times the rate paid for serving a single recipient. For three recipients sharing services, the rate paid to a personal care assistance provider agency for the shared services must not exceed twice the rate paid for serving a single recipient. These rates apply only when all criteria for shared services are met.

(d) Of the additional revenue for shared services provided to two recipients, the personal care assistance provider agency must use 90 percent for the purposes specified in paragraph (e). Of the additional revenue for shared services provided to three recipients, the personal care assistance provider agency must use 90 percent for the purposes specified in paragraph (e).

(e) A personal care assistance provider agency must use the percentages of additional revenue for shared services specified in paragraph (d) for the wages and wage-related costs of the personal care assistant providing the shared services. The personal care assistance provider agency must not use additional revenue for shared services to pay for mileage reimbursements, uniform allowances, health and dental insurance, life insurance, disability insurance, long-term care insurance, contributions to employee retirement accounts if the contribution is not a function of wages, or any other employee benefits.

Subd. 17a. **Enhanced rate.** (a) An enhanced rate of 107.5 percent of the rate paid for personal care assistance services shall be paid for services provided to persons who qualify for ten or more hours of personal care assistance services per day when provided by a personal care assistant who meets the requirements of subdivision 11, paragraph (d). This paragraph expires upon the effective date of paragraph (b).

(b) Effective January 1, 2026, or upon federal approval, whichever is later, an enhanced rate of 112.5 percent of the rate paid for personal care assistance services shall be paid for services provided to persons who qualify for ten or more hours of personal care assistance services per day when provided by a personal care assistant who meets the requirements of subdivision 11, paragraph (d).

(c) A personal care assistance provider must use all additional revenue attributable to the rate enhancements under this subdivision for the wages and wage-related costs of the personal care assistants, including any corresponding increase in the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, and workers' compensation premiums. The agency must not use the additional revenue attributable to any enhanced rate under this subdivision to pay for mileage reimbursement, health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, contributions to employee retirement accounts, or any other employee benefits.

(d) Any change in the eligibility criteria for the enhanced rate for personal care assistance services as described in this subdivision and referenced in subdivision 11, paragraph (d), does not constitute a change in a term or condition for individual providers as defined in section 256B.0711, and is not subject to the state's obligation to meet and negotiate under chapter 179A.

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, including premiums for family and medical benefit 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) 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 reassessment as required in subdivision 3a to determine continuing eligibility and service authorization;

(7) use the same personal care assistance choice provider agency if shared services are being used; and

(8) ensure that a personal care assistant driving the recipient under subdivision 1, paragraph (i), has a valid driver's license and the vehicle used is registered and insured according to Minnesota law.

(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:

(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, unemployment insurance, and labor market data required under section 256B.4912, subdivision 1a;

(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.

(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 email address;

(2) proof of surety bond coverage for each business location providing services. 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 purchased new annually, and must allow for recovery of costs and fees in pursuing a claim on the bond. Any action to obtain monetary recovery or sanctions from a surety bond must occur within six years from the date the debt is affirmed by a final agency decision. An agency decision is final when the right to appeal the debt has been exhausted or the time to appeal has expired under section 256B.064;

(3) proof of fidelity bond coverage in the amount of $20,000 for each business location providing service;

(4) proof of workers' compensation insurance coverage identifying the business location where personal care assistance services are provided;

(5) proof of liability insurance coverage identifying the business location where personal care assistance services are provided and naming the department as a certificate holder;

(6) 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;

(7) 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;

(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;

(8) a list of all training and classes that the personal care assistance provider agency requires of its staff providing personal care assistance services;

(9) documentation that the personal care assistance provider agency and staff have successfully completed all the training required by this section, including the requirements under subdivision 11, paragraph (d), if enhanced personal care assistance services are provided and submitted for an enhanced rate under subdivision 17a;

(10) documentation of the agency's marketing practices;

(11) disclosure of ownership, leasing, or management of all residential properties that is used or could be used for providing home care services;

(12) 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

(13) 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 submitting an application for enrollment of the agency as a provider. All personal care assistance provider agencies shall also require qualified professionals to complete the training required by subdivision 13 before submitting an application for 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 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.

(d) All surety bonds, fidelity bonds, workers' compensation insurance, and liability insurance required by this subdivision must be maintained continuously and purchased new annually. After initial enrollment, a provider must submit proof of bonds and required coverages at any time at the request of the commissioner. Services provided while there are lapses in coverage are not eligible for payment. Lapses in coverage may result in sanctions, including termination. The commissioner shall send instructions and a due date to submit the requested information to the personal care assistance provider agency.

Subd. 22. MS 2018 [Repealed, 1Sp2019 c 9 art 7 s 47]

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;

(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) 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;

(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;

(15) comply with the labor market reporting requirements described in section 256B.4912, subdivision 1a;

(16) document that the agency uses the additional revenue due to the enhanced rate under subdivision 17a for the wages and any corresponding increase in the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, and workers' compensation premiums of the PCAs whose services meet the requirements under subdivision 11, paragraph (d); and

(17) ensure that a personal care assistant driving a recipient under subdivision 1, paragraph (i), has a valid driver's license and the vehicle used is registered and insured according to Minnesota law.

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.

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; ventilator-dependent recipients.** (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, physician assistant, 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, including verification of the completion of training required under subdivision 11, paragraph (d), if personal care assistance services eligible for the enhanced rate are provided and submitted for reimbursement under subdivision 17a;

(v) supervisory visits;

(vi) evaluations of employment; and

(vii) signature on fraud statement;

(2) recipient files, including:

(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 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; 2016 c 158 art 1 s 113; 2019 c 50 art 1 s 72; 2019 c 54 art 2 s 20; 1Sp2019 c 9 art 2 s 120; art 5 s 35-42; art 7 s 33; 2020 c 115 art 4 s 125-128; 5Sp2020 c 3 art 10 s 1; 2021 c 30 art 1 s 15; 1Sp2021 c 7 art 13 s 13,14; 2022 c 58 s 145-149; 2022 c 98 art 4 s 33; art 17 s 10,26; 2023 c 59 art 1 s 5; 2023 c 61 art 1 s 12-16; 2024 c 80 art 2 s 74; 2024 c 108 art 1 s 12,13; 2024 c 115 art 16 s 41; 1Sp2025 c 3 art 17 s 9; 1Sp2025 c 9 art 2 s 11; 2026 c 121 art 4 s 27; art 9 s 13-16

256B.066 ORTHOTIC AND PROSTHETIC DEVICES, SUPPLIES, AND SERVICES.

Subdivision 1. **Definitions.** All terms used in this section have the meanings given them in section 62Q.665, subdivision 1.

Subd. 2. **Coverage requirements.** (a) Medical assistance covers orthotic and prosthetic devices, supplies, and services:

(1) furnished under an order by a prescribing physician or licensed health care prescriber who has authority in Minnesota to prescribe orthoses and prostheses. Coverage for orthotic and prosthetic devices, supplies, accessories, and services under this clause includes those devices or device systems, supplies, accessories, and services that are customized to the enrollee's needs;

(2) determined by the enrollee's provider to be the most appropriate model that meets the medical needs of the enrollee for purposes of performing physical activities, as applicable, including but not limited to running, biking, and swimming, and maximizing the enrollee's limb function; or

(3) for showering or bathing.

(b) The coverage set forth in paragraph (a) includes the repair and replacement of those orthotic and prosthetic devices, supplies, and services described therein.

(c) Coverage of a prosthetic or orthotic benefit must not be denied for an individual with limb loss or absence that would otherwise be covered for a nondisabled person seeking medical or surgical intervention to restore or maintain the ability to perform the same physical activity.

(d) If coverage for prosthetic or custom orthotic devices is provided, payment must be made for the replacement of a prosthetic or custom orthotic device or for the replacement of any part of the devices, without regard to useful lifetime restrictions, if an ordering health care provider determines that the provision of a replacement device, or a replacement part of a device, is necessary because:

(1) of a change in the physiological condition of the enrollee;

(2) of an irreparable change in the condition of the device or in a part of the device; or

(3) the condition of the device, or the part of the device, requires repairs and the cost of the repairs would be more than 60 percent of the cost of a replacement device or of the part being replaced.

Subd. 3. **Restrictions on coverage.** (a) Prior authorization may be required for orthotic and prosthetic devices, supplies, and services.

(b) A utilization review for a request for coverage of prosthetic or orthotic benefits must apply the most recent version of evidence-based treatment and fit criteria as recognized by relevant clinical specialists.

(c) Utilization review determinations must be rendered in a nondiscriminatory manner and must not deny coverage for habilitative or rehabilitative benefits, including protheses or orthoses, solely on the basis of an enrollee's actual or perceived disability.

(d) Evidence of coverage and any benefit denial letters must include language describing an enrollee's rights pursuant to paragraphs (b) and (c).

(e) Confirmation from a prescribing health care provider may be required if the prosthetic or custom orthotic device or part being replaced is less than three years old.

Subd. 4. **Managed care plan access to care.** (a) Managed care plans and county-based purchasing plans subject to this section must ensure access to medically necessary clinical care and to prosthetic and custom orthotic devices and technology from at least two distinct prosthetic and custom orthotic providers in the plan's provider network located in Minnesota.

(b) In the event that medically necessary covered orthoses and protheses are not available from an in-network provider, the plan must provide processes to refer an enrollee to an out-of-network provider and must fully reimburse the out-of-network provider at a mutually agreed upon rate less enrollee cost sharing determined on an in-network basis.

History: *2024 c 127 art 57 s 65*

NOTE: This section, as added by Laws 2024, chapter 127, article 57, section 65, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2024, chapter 127, article 57, section 65, the effective date.

256B.0671 COVERED MENTAL HEALTH SERVICES.

Subdivision 1. **Definitions.** (a) "Clinical trainee" means a staff person who is qualified under section 245I.04, subdivision 6.

(b) "Mental health practitioner" means a staff person who is qualified under section 245I.04, subdivision 4.

(c) "Mental health professional" means a staff person who is qualified under section 245I.04, subdivision 2.

Subd. 2. **Generally.** (a) An individual, organization, or government entity providing mental health services to a client under this section must obtain a criminal background study of each staff person or volunteer who is providing direct contact services to a client.

(b) An individual, organization, or government entity providing mental health services to a client under this section must comply with all responsibilities that chapter 245I assigns to a license holder, except section 245I.011, subdivision 1, unless all of the individual's, organization's, or government entity's treatment staff are qualified as mental health professionals.

(c) An individual, organization, or government entity providing mental health services to a client under this section must comply with the following requirements if all of the license holder's treatment staff are qualified as mental health professionals:

(1) provider qualifications and scopes of practice under section 245I.04;

(2) maintaining and updating personnel files under section 245I.07;

(3) documenting under section 245I.08;

(4) maintaining and updating client files under section 245I.09;

(5) completing client assessments and treatment planning under section 245I.10;

(6) providing clients with health services and medications under section 245I.11; and

(7) respecting and enforcing client rights under section 245I.12.

Subd. 3. **Adult day treatment services.** (a) Medical assistance covers adult day treatment (ADT) services that are provided under contract with the county board. Adult day treatment payment is subject to the conditions in paragraphs (b) to (e). The provider must make reasonable and good faith efforts to report individual client outcomes to the commissioner using instruments, protocols, and forms approved by the commissioner.

(b) Adult day treatment is an intensive psychotherapeutic treatment to reduce or relieve the effects of mental illness on a client to enable the client to benefit from a lower level of care and to live and function more independently in the community. Adult day treatment services must be provided to a client to stabilize the client's mental health and to improve the client's independent living and socialization skills. Adult day treatment must consist of at least one hour of group psychotherapy and must include group time focused on rehabilitative interventions or other therapeutic services that a multidisciplinary team provides to each client. Adult day treatment services are not a part of inpatient or residential treatment services. The following providers may apply to become adult day treatment providers:

(1) a hospital with Centers for Medicare and Medicaid Services approved hospital accreditation and licensed under sections 144.50 to 144.55;

(2) a community mental health center under section 256B.0625, subdivision 5; or

(3) an entity that is under contract with the county board to operate a program that meets the requirements of section 245.4712, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475.

(c) An adult day treatment services provider must:

(1) ensure that the commissioner has approved of the organization as an adult day treatment provider organization;

(2) ensure that a multidisciplinary team provides ADT services to a group of clients. A mental health professional must supervise each multidisciplinary staff person who provides ADT services;

(3) make ADT services available to the client at least two days a week for at least three consecutive hours per day. ADT services may be longer than three hours per day, but medical assistance may not reimburse a provider for more than 15 hours per week;

(4) provide ADT services to each client that includes group psychotherapy by a mental health professional or clinical trainee and daily rehabilitative interventions by a mental health professional, clinical trainee, or mental health practitioner; and

(5) include ADT services in the client's individual treatment plan, when appropriate. The adult day treatment provider must:

(i) complete a functional assessment of each client under section 245I.10, subdivision 9;

(ii) notwithstanding section 245I.10, subdivision 8, review the client's progress and update the individual treatment plan at least every 90 days until the client is discharged from the program; and

(iii) include a discharge plan for the client in the client's individual treatment plan.

(d) To be eligible for adult day treatment, a client must:

(1) be 18 years of age or older;

(2) not reside in a nursing facility, hospital, institute of mental disease, or state-operated treatment center unless the client has an active discharge plan that indicates a move to an independent living setting within 180 days;

(3) have the capacity to engage in rehabilitative programming, skills activities, and psychotherapy in the structured, therapeutic setting of an adult day treatment program and demonstrate measurable improvements in functioning resulting from participation in the adult day treatment program;

(4) have a level of care assessment under section 245I.02, subdivision 19, recommending that the client participate in services with the level of intensity and duration of an adult day treatment program; and

(5) have the recommendation of a mental health professional for adult day treatment services. The mental health professional must find that adult day treatment services are medically necessary for the client.

(e) Medical assistance does not cover the following services as adult day treatment services:

(1) services that are primarily recreational or that are provided in a setting that is not under medical supervision, including sports activities, exercise groups, craft hours, leisure time, social hours, meal or snack time, trips to community activities, and tours;

(2) social or educational services that do not have or cannot reasonably be expected to have a therapeutic outcome related to the client's mental illness;

(3) consultations with other providers or service agency staff persons about the care or progress of a client;

(4) prevention or education programs that are provided to the community;

(5) day treatment for clients with a primary diagnosis of a substance use disorder;

(6) day treatment provided in the client's home;

(7) psychotherapy for more than two hours per day; and

(8) participation in meal preparation and eating that is not part of a clinical treatment plan to address the client's eating disorder.

Subd. 4. **Explanation of findings.** (a) Medical assistance covers an explanation of findings that a mental health professional or clinical trainee provides when the provider has obtained the authorization from the client or the client's representative to release the information.

(b) A mental health professional or clinical trainee provides an explanation of findings to assist the client or related parties in understanding the results of the client's testing or diagnostic assessment and the client's mental illness, and provides professional insight that the client or related parties need to carry out a client's treatment plan. Related parties may include the client's family and other natural supports and other service providers working with the client.

(c) An explanation of findings is not paid for separately when a mental health professional or clinical trainee explains the results of psychological testing or a diagnostic assessment to the client or the client's representative as part of the client's psychological testing or a diagnostic assessment.

Subd. 5. **Child and family psychoeducation services.** (a) Medical assistance covers child and family psychoeducation services provided to a child under age 21 and the child's family members, when determined to be medically necessary due to a mental health condition or diagnosed mental illness identified in the child's individual treatment plan and provided by a mental health professional who is qualified under section 245I.04, subdivision 2, and practicing within the scope of practice under section 245I.04, subdivision 3; a mental health practitioner who is qualified under section 245I.04, subdivision 4, and practicing within the scope of practice under section 245I.04, subdivision 5; or a clinical trainee who is qualified under section 245I.04, subdivision 6, and practicing within the scope of practice under section 245I.04, subdivision 7.

(b) "Child and 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.

(c) Child and family psychoeducation services include individual, family, or group skills development or training to:

(1) support the development of psychosocial skills that are medically necessary to rehabilitate the child to an age-appropriate developmental trajectory when the child's development was disrupted by a mental health condition or diagnosed mental illness; or

(2) enable the child to self-monitor, compensate for, cope with, counteract, or replace skills deficits or maladaptive skills acquired over the course of the child's mental health condition or mental illness.

(d) Skills development or training delivered to a child or the child's family under this subdivision must be targeted to the specific deficits related to the child's mental health condition or mental illness and must be prescribed in the child's individual treatment plan. Group skills training may be provided to multiple recipients who, because of the nature of their emotional, behavioral, or social functional ability, may benefit from interaction in a group setting.

Subd. 6. **Dialectical behavior therapy.** (a) Medical assistance covers intensive mental health outpatient treatment for dialectical behavior therapy. A dialectical behavior therapy provider must make reasonable and good faith efforts to report individual client outcomes to the commissioner using instruments and protocols that are approved by the commissioner.

(b) "Dialectical behavior therapy" means an evidence-based treatment approach that a mental health professional or clinical trainee provides to a client or a group of clients in an intensive outpatient treatment program using a combination of individualized rehabilitative and psychotherapeutic interventions. A dialectical behavior therapy program involves: individual dialectical behavior therapy, group skills training, telephone coaching, and team consultation meetings.

(c) To be eligible for dialectical behavior therapy, a client must:

(1) have mental health needs that available community-based services cannot meet or that the client must receive concurrently with other community-based services;

(2) have either:

(i) a diagnosis of borderline personality disorder; or

(ii) multiple mental health diagnoses, exhibit behaviors characterized by impulsivity or intentional self-harm, and be at significant risk of death, morbidity, disability, or severe dysfunction in multiple areas of the client's life;

(3) be cognitively capable of participating in dialectical behavior therapy as an intensive therapy program and be able and willing to follow program policies and rules to ensure the safety of the client and others; and

(4) be at significant risk of one or more of the following if the client does not receive dialectical behavior therapy:

(i) having a mental health crisis;

(ii) requiring a more restrictive setting such as hospitalization;

(iii) decompensating; or

(iv) engaging in intentional self-harm behavior.

(d) Individual dialectical behavior therapy combines individualized rehabilitative and psychotherapeutic interventions to treat a client's suicidal and other dysfunctional behaviors and to reinforce a client's use of adaptive skillful behaviors. A mental health professional or clinical trainee must provide individual dialectical behavior therapy to a client. A mental health professional or clinical trainee providing dialectical behavior therapy to a client must:

(1) identify, prioritize, and sequence the client's behavioral targets;

(2) treat the client's behavioral targets;

(3) assist the client in applying dialectical behavior therapy skills to the client's natural environment through telephone coaching outside of treatment sessions;

(4) measure the client's progress toward dialectical behavior therapy targets;

(5) help the client manage mental health crises and life-threatening behaviors; and

(6) help the client learn and apply effective behaviors when working with other treatment providers.

(e) Group skills training combines individualized psychotherapeutic and psychiatric rehabilitative interventions conducted in a group setting to reduce the client's suicidal and other dysfunctional coping behaviors and restore function. Group skills training must teach the client adaptive skills in the following areas: (1) mindfulness; (2) interpersonal effectiveness; (3) emotional regulation; and (4) distress tolerance.

(f) Group skills training must be provided by two mental health professionals or by a mental health professional co-facilitating with a clinical trainee or a mental health practitioner. Individual skills training must be provided by a mental health professional, a clinical trainee, or a mental health practitioner.

(g) Before a program provides dialectical behavior therapy to a client, the commissioner must certify the program as a dialectical behavior therapy provider. To qualify for certification as a dialectical behavior therapy provider, a provider must:

(1) allow the commissioner to inspect the provider's program;

(2) provide evidence to the commissioner that the program's policies, procedures, and practices meet the requirements of this subdivision and chapter 245I;

(3) be enrolled as a MHCP provider; and

(4) have a manual that outlines the program's policies, procedures, and practices that meet the requirements of this subdivision.

Subd. 7. **Mental health clinical care consultation.** (a) 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 mental health professional or a clinical trainee.

(b) "Clinical care consultation" means communication from a treating mental health professional to other providers or educators not under the treatment 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. 8. **Neuropsychological assessment.** (a) Medical assistance covers a client's neuropsychological assessment.

(b) "Neuropsychological assessment" means a specialized clinical assessment of the client's underlying cognitive abilities related to thinking, reasoning, and judgment that is conducted by a qualified neuropsychologist. A neuropsychological assessment must include a face-to-face interview with the client, interpretation of the test results, and preparation and completion of a report.

(c) A client is eligible for a neuropsychological assessment if the client meets at least one of the following criteria:

(1) the client has a known or strongly suspected brain disorder based on the client's medical history or the client's prior neurological evaluation, including a history of significant head trauma, brain tumor, stroke, seizure disorder, multiple sclerosis, neurodegenerative disorder, significant exposure to neurotoxins, central nervous system infection, metabolic or toxic encephalopathy, fetal alcohol syndrome, or congenital malformation of the brain; or

(2) the client has cognitive or behavioral symptoms that suggest that the client has an organic condition that cannot be readily attributed to functional psychopathology or suspected neuropsychological impairment in addition to functional psychopathology. The client's symptoms may include:

(i) having a poor memory or impaired problem solving;

(ii) experiencing change in mental status evidenced by lethargy, confusion, or disorientation;

(iii) experiencing a deteriorating level of functioning;

(iv) displaying a marked change in behavior or personality;

(v) in a child or an adolescent, having significant delays in acquiring academic skill or poor attention relative to peers;

(vi) in a child or an adolescent, having reached a significant plateau in expected development of cognitive, social, emotional, or physical functioning relative to peers; and

(vii) in a child or an adolescent, significant inability to develop expected knowledge, skills, or abilities to adapt to new or changing cognitive, social, emotional, or physical demands.

(d) The neuropsychological assessment must be completed by a neuropsychologist who:

(1) was awarded a diploma by the American Board of Clinical Neuropsychology, the American Board of Professional Neuropsychology, or the American Board of Pediatric Neuropsychology;

(2) earned a doctoral degree in psychology from an accredited university training program and:

(i) completed an internship or its equivalent in a clinically relevant area of professional psychology;

(ii) completed the equivalent of two full-time years of experience and specialized training, at least one of which is at the postdoctoral level, supervised by a clinical neuropsychologist in the study and practice of clinical neuropsychology and related neurosciences; and

(iii) holds a current license to practice psychology independently according to sections 148.88 to 148.98;

(3) is licensed or credentialed by another state's board of psychology examiners in the specialty of neuropsychology using requirements equivalent to requirements specified by one of the boards named in clause (1); or

(4) was approved by the commissioner as an eligible provider of neuropsychological assessments prior to December 31, 2010.

Subd. 9. **Neuropsychological testing.** (a) Medical assistance covers neuropsychological testing for clients.

(b) "Neuropsychological testing" means administering standardized tests and measures designed to evaluate the client's ability to attend to, process, interpret, comprehend, communicate, learn, and recall information and use problem solving and judgment.

(c) Medical assistance covers neuropsychological testing of a client when the client:

(1) has a significant mental status change that is not a result of a metabolic disorder and that has failed to respond to treatment;

(2) is a child or adolescent with a significant plateau in expected development of cognitive, social, emotional, or physical function relative to peers;

(3) is a child or adolescent with a significant inability to develop expected knowledge, skills, or abilities to adapt to new or changing cognitive, social, physical, or emotional demands; or

(4) has a significant behavioral change, memory loss, or suspected neuropsychological impairment in addition to functional psychopathology, or other organic brain injury or one of the following:

(i) traumatic brain injury;

(ii) stroke;

(iii) brain tumor;

(iv) substance use disorder;

(v) cerebral anoxic or hypoxic episode;

(vi) central nervous system infection or other infectious disease;

(vii) neoplasms or vascular injury of the central nervous system;

(viii) neurodegenerative disorders;

(ix) demyelinating disease;

(x) extrapyramidal disease;

(xi) exposure to systemic or intrathecal agents or cranial radiation known to be associated with cerebral dysfunction;

(xii) systemic medical conditions known to be associated with cerebral dysfunction, including renal disease, hepatic encephalopathy, cardiac anomaly, sickle cell disease, and related hematologic anomalies, and autoimmune disorders, including lupus, erythematosus, or celiac disease;

(xiii) congenital genetic or metabolic disorders known to be associated with cerebral dysfunction, including phenylketonuria, craniofacial syndromes, or congenital hydrocephalus;

(xiv) severe or prolonged nutrition or malabsorption syndromes; or

(xv) a condition presenting in a manner difficult for a clinician to distinguish between the neurocognitive effects of a neurogenic syndrome, including dementia or encephalopathy; and a major depressive disorder when adequate treatment for major depressive disorder has not improved the client's neurocognitive functioning; or another disorder, including autism, selective mutism, anxiety disorder, or reactive attachment disorder.

(d) Neuropsychological testing must be administered or clinically supervised by a qualified neuropsychologist under subdivision 8, paragraph (c).

(e) Medical assistance does not cover neuropsychological testing of a client when the testing is:

(1) primarily for educational purposes;

(2) primarily for vocational counseling or training;

(3) for personnel or employment testing;

(4) a routine battery of psychological tests given to the client at the client's inpatient admission or during a client's continued inpatient stay; or

(5) for legal or forensic purposes.

Subd. 10. **Psychological testing.** (a) Medical assistance covers psychological testing of a client.

(b) "Psychological testing" means the use of tests or other psychometric instruments to determine the status of a client's mental, intellectual, and emotional functioning.

(c) The psychological testing must:

(1) be administered or supervised by a licensed psychologist qualified under section 245I.04, subdivision 2, clause (3), who is competent in the area of psychological testing; and

(2) be validated in a face-to-face interview between the client and a licensed psychologist or a clinical trainee in psychology under the treatment supervision of a licensed psychologist under section 245I.06.

(d) A licensed psychologist must supervise the administration, scoring, and interpretation of a client's psychological tests when a clinical psychology trainee, technician, psychometrist, or psychological assistant

or a computer-assisted psychological testing program completes the psychological testing of the client. The report resulting from the psychological testing must be signed by the licensed psychologist who conducts the face-to-face interview with the client. The licensed psychologist or a staff person who is under treatment supervision must place the client's psychological testing report in the client's record and release one copy of the report to the client and additional copies to individuals authorized by the client to receive the report.

Subd. 11. **Psychotherapy.** (a) Medical assistance covers psychotherapy for a client.

(b) "Psychotherapy" means treatment of a client with mental illness that applies to the most appropriate psychological, psychiatric, psychosocial, or interpersonal method that conforms to prevailing community standards of professional practice to meet the mental health needs of the client. Medical assistance covers psychotherapy if a mental health professional or a clinical trainee provides psychotherapy to a client.

(c) "Individual psychotherapy" means psychotherapy that a mental health professional or clinical trainee designs for a client.

(d) "Family psychotherapy" means psychotherapy that a mental health professional or clinical trainee designs for a client and one or more of the client's family members or primary caregiver whose participation is necessary to accomplish the client's treatment goals. Family members or primary caregivers participating in a therapy session do not need to be eligible for medical assistance for medical assistance to cover family psychotherapy. For purposes of this paragraph, "primary caregiver whose participation is necessary to accomplish the client's treatment goals" excludes shift or facility staff persons who work at the client's residence. Medical assistance payments for family psychotherapy are limited to face-to-face sessions during which the client is present throughout the session, unless the mental health professional or clinical trainee believes that the client's exclusion from the family psychotherapy session is necessary to meet the goals of the client's individual treatment plan. If the client is excluded from a family psychotherapy session, a mental health professional or clinical trainee must document the reason for the client's exclusion and the length of time that the client is excluded. The mental health professional must also document any reason that a member of the client's family is excluded from a psychotherapy session.

(e) Group psychotherapy is appropriate for a client who, because of the nature of the client's emotional, behavioral, or social dysfunctions, can benefit from treatment in a group setting. For a group of three to eight clients, at least one mental health professional or clinical trainee must provide psychotherapy to the group. For a group of nine to 12 clients, a team of at least two mental health professionals or two clinical trainees or one mental health professional and one clinical trainee must provide psychotherapy to the group. Medical assistance will cover group psychotherapy for a group of no more than 12 persons.

(f) A multiple-family group psychotherapy session is eligible for medical assistance if a mental health professional or clinical trainee designs the psychotherapy session for at least two but not more than five families. A mental health professional or clinical trainee must design multiple-family group psychotherapy sessions to meet the treatment needs of each client. If the client is excluded from a psychotherapy session, the mental health professional or clinical trainee must document the reason for the client's exclusion and the length of time that the client was excluded. The mental health professional or clinical trainee must document any reason that a member of the client's family was excluded from a psychotherapy session.

Subd. 11a. **Psychotherapy for crisis.** (a) Medical assistance covers psychotherapy for crisis when a recipient is in need of an immediate response due to an increase of mental illness symptoms that put the recipient at risk of one of the following:

(1) experiencing a life-threatening mental health crisis;

(2) needing a higher level of care;

(3) worsening symptoms without mental health intervention;

(4) harm to self or others, or property damage; or

(5) significant disruption of functioning in at least one life area.

(b) "Psychotherapy for crisis" means treatment of a client to reduce the client's mental health crisis through immediate assessment and psychotherapeutic interventions. Psychotherapy for crisis must include:

(1) emergency assessment of the crisis situation;

(2) mental status exam;

(3) psychotherapeutic interventions to reduce the crisis; and

(4) development of a post-crisis plan that addresses the recipient's coping skills and community resources.

Subd. 12. **Partial hospitalization.** (a) Medical assistance covers a client's partial hospitalization.

(b) "Partial hospitalization" means a provider's time-limited, structured program of psychotherapy and other therapeutic services, as defined in United States Code, title 42, chapter 7, subchapter XVIII, part E, section 1395x(ff), that a multidisciplinary staff person provides in an outpatient hospital facility or community mental health center that meets Medicare requirements to provide partial hospitalization services to a client.

(c) Partial hospitalization is an appropriate alternative to inpatient hospitalization for a client who is experiencing an acute episode of mental illness who meets the criteria for an inpatient hospital admission under Minnesota Rules, part 9505.0520, subpart 1, and who has family and community resources that support the client's residence in the community. Partial hospitalization consists of multiple intensive short-term therapeutic services for a client that a multidisciplinary staff person provides to a client to treat the client's mental illness.

Subd. 13. **Diagnostic assessments.** Medical assistance covers a client's diagnostic assessments that a mental health professional or clinical trainee completes under section 245I.10.

Subd. 14. **Billing limits.** Child and family psychoeducation services under this section must not exceed two hours per day, three days per week per recipient.

History: *2021 c 30 art 15 s 17; 2022 c 98 art 4 s 34; 2023 c 25 s 140; 2024 c 115 art 7 s 3; 2024 c 127 art 61 s 22,23; 2026 c 121 art 6 s 17*

256B.07 MS 1986 [Repealed, 1987 c 403 art 2 s 164]

256B.0701 RECUPERATIVE CARE SERVICES.

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

(b) "Habitability inspection" means an inspection that meets the requirements of subdivision 13.

(c) "Provider" means a recuperative care provider that meets the standards for medical respite care programs most recently published by the National Institute for Medical Respite Care.

(d) "Recuperative care" means a model of care that prevents hospitalization or that provides postacute medical care and support services for recipients experiencing homelessness who are too ill or frail to recover from a physical illness or injury while living in a shelter or are otherwise unhoused but who are not sick enough to be hospitalized or remain hospitalized, or to need other levels of care.

Subd. 2. **Recuperative care settings.** Recuperative care may be provided in any setting that meets the habitability inspection requirements in subdivision 13, including but not limited to homeless shelters, congregate care settings, single room occupancy settings, or supportive housing, so long as the provider of recuperative care or provider of housing is able to provide to the recipient within the designated setting, at a minimum:

(1) 24-hour access to a bed and bathroom;

(2) access to three meals a day;

(3) availability to environmental services;

(4) access to a telephone;

(5) a secure place to store belongings; and

(6) staff available within the setting to provide a wellness check as needed, but at a minimum, at least once every 24 hours.

Subd. 3. **Eligibility.** To be eligible for recuperative care services, a recipient must:

(1) not be a child;

(2) be experiencing homelessness;

(3) be in need of short-term acute medical care for a period of no more than 60 days;

(4) meet clinical criteria, as established by the commissioner, that indicates that the recipient needs recuperative care; and

(5) not have behavioral health needs that are greater than what can be managed by the provider within the setting.

Subd. 4. **Total payment rates.** Total payment rates for recuperative care consist of the recuperative care services rate and the recuperative care facility rate.

Subd. 5. **Recuperative care services rate.** The recuperative care services rate is for the services provided to the recipient and must be a bundled daily per diem payment of at least $300 per day. Services provided within the bundled payment may include but are not limited to:

(1) basic nursing care, including:

(i) monitoring a patient's physical health and pain level;

(ii) providing wound care;

(iii) medication support;

(iv) patient education;

(v) immunization review and update; and

(vi) establishing clinical goals for the recuperative care period and discharge plan;

(2) care coordination, including:

(i) initial assessment of medical, behavioral, and social needs;

(ii) development of a care plan;

(iii) support and referral assistance for legal services, housing, community social services, case management, health care benefits, health and other eligible benefits, and transportation needs and services; and

(iv) monitoring and follow-up to ensure that the care plan is effectively implemented to address the medical, behavioral, and social needs;

(3) basic behavioral needs, including counseling and peer support, that can be provided in the recuperative care setting; and

(4) services provided by a community health worker as defined under section 256B.0625, subdivision 49.

Subd. 6. **Recuperative care facility rate.** (a) The recuperative care facility rate is for facility costs and must be paid from state money in an amount equal to the MSA equivalent rate as defined in section 256I.03, subdivision 11a, at the time the recuperative care services were provided. The eligibility standards in chapter 256I do not apply to the recuperative care facility rate. The recuperative care facility rate is only paid when the recuperative care services rate is paid to a provider. Providers may opt to only receive the recuperative care services rate.

(b) Before a recipient is discharged from a recuperative care setting, the provider must ensure that the recipient's medical condition is stabilized or that the recipient is being discharged to a setting that is able to meet that recipient's needs.

Subd. 7. **Extended stay.** If a recipient requires care exceeding the 60-day limit described in subdivision 3, the provider may request in a format prescribed by the commissioner an extension to continue payments until the recipient is discharged.

Subd. 8. **Report.** (a) The commissioner must submit an initial report on coverage of recuperative care services to the chairs and ranking minority members of the legislative committees having jurisdiction over health and human services finance and policy by February 1, 2025, and a final report by February 1, 2027. The reports must include but are not limited to:

(1) a list of the recuperative care services in Minnesota and the number of recipients;

(2) the estimated return on investment, including health care savings due to reduced hospitalizations;

(3) follow-up information, if available, on whether recipients' hospital visits decreased since recuperative care services were provided compared to before the services were provided; and

(4) any other information that can be used to determine the effectiveness of the program and its funding, including recommendations for improvements to the program.

(b) This subdivision expires upon submission of the final report.

Subd. 9. **Provider qualifications and duties.** A provider is eligible for reimbursement under this section only if the provider:

(1) is confirmed by the commissioner as an eligible provider after a pre-enrollment risk assessment under subdivision 10;

(2) is enrolled as a medical assistance Minnesota health care program provider and meets all applicable provider standards and requirements;

(3) demonstrates compliance with federal and state laws and policies for recuperative care services as determined by the commissioner;

(4) complies with background study requirements under chapter 245C and maintains documentation of background study requests and results;

(5) provides at the time of enrollment, reenrollment, and revalidation in a format determined by the commissioner, proof of surety bond coverage for each business location providing services. Upon new enrollment, or if the provider's medical assistance revenue in the previous calendar year is $300,000 or less, the provider agency must purchase a surety bond of $50,000. If the provider's medical assistance 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 purchased new annually, and must allow for recovery of costs and fees in pursuing a claim on the bond. Any action to obtain monetary recovery or sanctions from a surety bond must occur within six years from the date the debt is affirmed by a final agency decision. An agency decision is final when the right to appeal the debt has been exhausted or the time to appeal has expired under section 256B.064;

(6) ensures all controlling individuals and employees of the agency complete annual vulnerable adult training;

(7) completes compliance training as required under section 256B.0446, subdivision 2; and

(8) complies with the habitability inspection requirements in subdivision 13.

Subd. 10. **Pre-enrollment risk assessment.** (a) Prior to enrolling a recuperative care provider, the commissioner must complete a pre-enrollment risk assessment of the provider seeking to enroll to confirm the provider's eligibility and the provider's ability to meet the requirements of this section. In completing this assessment, the commissioner must consider:

(1) the potential provider's history of performing services similar to those required by this section;

(2) whether the services require the potential provider to perform duties at a significantly increased scale and, if so, whether the potential provider has the capability and organizational capacity to do so;

(3) the potential provider's financial information and internal controls; and

(4) the potential provider's compliance with other state and federal requirements, including but not limited to debarment and suspension status, and standing with the secretary of state, if applicable.

(b) At any time when completing the pre-enrollment risk assessment, if the commissioner determines that the potential provider does not have a history of performing similar duties, the potential provider does not demonstrate the capability and capacity to perform the duties at the scale and pace required, or the results of the financial information review raise concern, then the commissioner may deem the potential provider ineligible and deny or rescind enrollment. A potential provider may appeal a decision regarding the provider's

eligibility in writing within 30 business days. The commissioner must notify each potential provider of the commissioner's final decision regarding the provider's eligibility.

(c) This subdivision is effective July 1, 2025. Any recuperative care provider enrolled before July 1, 2025, that billed for services on or after January 1, 2024, must complete the pre-enrollment risk assessment on a schedule determined by the commissioner and no later than July 1, 2026, to remain eligible. Any provider enrolled before July 1, 2025, that has not billed for services on or after January 1, 2024, must complete the pre-enrollment risk assessment to remain eligible.

Subd. 11. MS 2025 Supp [Repealed, 2026 c 121 art 3 s 64]

Subd. 12. **Requirements for provider enrollment; documentation of habitability inspection.** (a) Effective July 1, 2025, to enroll as a recuperative care provider, a provider must submit to the commissioner proof that a habitability inspection of the proposed service setting has been performed and a qualified inspector has deemed the setting habitable.

(b) Any recuperative care provider enrolled prior to July 1, 2025, must submit to the commissioner by July 1, 2026, proof that a habitability inspection of the service setting has been performed and a qualified inspector has deemed the setting habitable.

Subd. 13. **Habitability inspection requirements.** (a) A recuperative care provider providing recuperative care services in an unlicensed setting must ensure that the unlicensed setting is inspected by a qualified inspector with demonstrated knowledge of housing inspection standards and professional experience conducting home inspections. The habitability inspection must include an assessment of potential home-based health and safety risks to ensure the living environment does not adversely affect the occupants' health and safety. Inspectors must evaluate both the habitability and environmental safety of the property, including but not limited to the following characteristics of the unlicensed setting:

(1) adequacy of space for the individuals being served;

(2) indoor air quality and ventilation;

(3) adequacy of safe water supply;

(4) cleanliness of the setting, including kitchen, bathroom, and living spaces;

(5) adequacy of electrical service, outlets, and lighting and absence of electrical hazards;

(6) potential lead exposure;

(7) conditions that may affect health;

(8) conditions that may affect safety;

(9) condition of the building foundation and exterior, including accessibility; and

(10) condition and functionality of equipment for heating, cooling, and ventilation and plumbing.

(b) A recuperative care provider must not provide services in an unlicensed setting prior to receiving a habitability inspection and documentation that the inspector deems the setting habitable. The recuperative care provider must maintain documentation that the inspection occurred and the results of the inspection.

History: *2023 c 70 art 1 s 27; 2024 c 127 art 55 s 11; 1Sp2025 c 9 art 7 s 16-22; 2026 c 95 art 4 s 15; 2026 c 121 art 3 s 47; art 4 s 28*

256B.0705 MS 2018 [Repealed, 1Sp2019 c 9 art 5 s 94]

256B.071 Subdivision 1. MS 2008 [Repealed, 2009 c 79 art 8 s 86]

Subd. 2. MS 2008 [Repealed, 2009 c 79 art 8 s 86]

Subd. 3. MS 2008 [Repealed, 2009 c 79 art 8 s 86]

Subd. 4. MS 2008 [Repealed, 2009 c 79 art 8 s 86]

Subd. 5. MS 2000 [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 under section 256B.8502, subdivision 6; consumer-directed community supports 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, chapter 256S and sections 256B.092 and 256B.49, and under the alternative care program under section 256B.0913; the personal care assistance choice program under 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 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;

(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.

(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; 2019 c 54 art 2 s 21; 1Sp2020 c 2 art 2 s 21; 2026 c 121 art 9 s 61*

256B.072 PERFORMANCE REPORTING AND QUALITY IMPROVEMENT SYSTEM.

Subdivision 1. **Performance measures.** (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 section 62U.02, subdivision 1, paragraph (a), clause (1). 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 website 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 website suitable for this purpose.

(e) Performance measures must be stratified as provided under section 62U.02, subdivision 1, paragraph (c), and risk-adjusted as specified in section 62U.02, subdivision 3, paragraph (b).

(f) Notwithstanding paragraph (b), by January 1, 2019, the commissioner shall consider and appropriately adjust quality metrics and benchmarks for providers who primarily serve socioeconomically complex patient populations and request to be scored on additional measures in this subdivision. This applies to all Minnesota health care programs, including for patient populations enrolled in health plans, county-based purchasing plans, or managed care organizations and for value-based purchasing arrangements, including, but not limited to, initiatives operating under sections 62U.03, 256B.0753, 256B.0755, 256B.0756, and 256B.0757.

(g) Assessment of patient satisfaction with chronic pain management for the purpose of determining compensation or quality incentive payments is prohibited. The commissioner shall require managed care plans, county-based purchasing plans, and integrated health partnerships to comply with this requirement as a condition of contract. This prohibition does not apply to:

(1) assessing patient satisfaction with chronic pain management for the purpose of quality improvement; and

(2) pain management as a part of a palliative care treatment plan to treat patients with cancer or patients receiving hospice care.

Subd. 2. **Adjustment of quality metrics for special populations.** Notwithstanding subdivision 1, paragraph (b), by January 1, 2019, the commissioner shall consider and appropriately adjust quality metrics and benchmarks for providers who primarily serve socioeconomically complex patient populations and request to be scored on additional measures in this subdivision. This requirement applies to all medical assistance and MinnesotaCare programs and enrollees, including persons enrolled in managed care and county-based purchasing plans or other managed care organizations, persons receiving care under

fee-for-service, and persons receiving care under value-based purchasing arrangements, including but not limited to initiatives operating under sections 62U.03, 256B.0753, 256B.0755, 256B.0756, and 256B.0757.

History: *1Sp2005 c 4 art 8 s 43; 2015 c 71 art 9 s 16; 1Sp2017 c 6 art 4 s 39; 2020 c 115 art 3 s 39*

256B.073 ELECTRONIC VISIT VERIFICATION.

Subdivision 1. **Documentation; establishment and operation.** The commissioner of human services shall establish and maintain the requirements and standards for the ongoing operation of electronic visit verification to comply with the 21st Century Cures Act, Public Law 114-255. Within available appropriations, the commissioner shall take steps to comply with the electronic visit verification requirements in the 21st Century Cures Act, Public Law 114-255.

Subd. 2. **Definitions.** (a) For purposes of this section, the terms in this subdivision have the meanings given.

(b) "Data aggregator" means the entity designated by the commissioner to collect, store, and transmit electronic visit verification data from providers and third-party systems to the commissioner in accordance with the standards and requirements established under this section.

(c) "Electronic visit verification" or "EVV" means the process required under this section and United States Code, title 42, section 1396b(l), used to electronically verify the:

(1) type of service performed;

(2) individual receiving the service;

(3) date of the service;

(4) location of the service delivery;

(5) individual providing the service; and

(6) time the service begins and ends.

(d) "Electronic visit verification data" means information collected through an electronic visit verification system, including data elements required under United States Code, title 42, section 1396b(l), and any additional data elements specified by the commissioner under this section.

(e) "Electronic visit verification system" means a system used to collect, verify, and transmit electronic visit verification data to the commissioner or the commissioner's designated data aggregator that complies with the 21st Century Cures Act, Public Law 114-255, and the requirements of subdivision 3.

(f) "Electronic visit verification vendor" means any entity that develops, provides, or supports an electronic visit verification system, including the state-provided vendor and any third-party vendor.

(g) "Financial management services provider" means an entity enrolled with the commissioner to provide financial management services under section 256B.85 or other applicable law and responsible for fiscal, payroll, and reporting functions on behalf of participant employers.

(h) "Home health agency" means a home care provider agency that is Medicare certified under Code of Federal Regulations, title 42, part 484, and licensed as a home care provider under chapter 144A.

(i) "Individual" means a person who receives services subject to electronic visit verification under the medical assistance program.

(j) "Managed care organization" means a public or private organization that contracts with the commissioner under section 256B.69 or other applicable law to deliver health care services to individuals eligible for medical assistance or MinnesotaCare.

(k) "Manual visit" means a visit:

(1) entered administratively and not by the caregiver at the time of service delivery; or

(2) where data elements are edited after the time of service delivery.

(l) "Provider" means an individual or organization that meets one or more of the following conditions:

(1) is enrolled as a Minnesota health care programs provider;

(2) provides services through a managed care organization under contract with the commissioner under section 256B.69;

(3) is a financial management services provider; or

(4) is a participant employer under section 256B.85, subdivision 7, or an employer of record that is directing services under section 256B.49, subdivision 16.

(m) "Service" means one of the following:

(1) personal care assistance services as defined in section 256B.0625, subdivision 19a, and provided according to section 256B.0659;

(2) community first services and supports under section 256B.85;

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

(4) adult companion services;

(5) adult day services;

(6) adult rehabilitative mental health services;

(7) assertive community treatment;

(8) early intensive developmental and behavioral intervention;

(9) integrated community supports;

(10) nonemergency medical transportation services;

(11) recovery peer support;

(12) home and community-based services reimbursed at an hourly or specified minute-based rate and provided according to a federally approved waiver plan as authorized under chapter 256S or section 256B.0913, 256B.092, or 256B.49; or

(13) other medical supplies and equipment or home and community-based services that are required to be electronically verified by the 21st Century Cures Act, Public Law 114-255.

(n) "State-provided electronic visit verification system" means the electronic visit verification system made available by the commissioner to providers at no cost for services subject to federal electronic visit verification requirements.

(o) "Third-party electronic visit verification system" means an electronic visit verification system purchased or operated by a provider or vendor other than the state-provided system designated by the commissioner.

(p) "Verification method" means the electronic process used to capture and verify visit information, including telephone, fixed visit verification devices, or mobile applications, as approved by the commissioner.

(q) "Visit" means a single occurrence of service delivery subject to electronic visit verification.

(r) "Worker" means an individual who provides personal care assistance services, community first services and supports, home health services, consumer-directed community supports, or other services identified by the commissioner as subject to electronic visit.

Subd. 3. **Requirements.** (a) In administering electronic visit verification, the commissioner must ensure that the system and related requirements:

(1) are administratively and financially reasonable for providers of services;

(2) support continued access to services and are designed to avoid disruption to service delivery or receipt;

(3) consider existing best practices and use of electronic visit verification;

(4) are conducted according to all state and federal laws;

(5) are effective methods for preventing fraud when balanced against the requirements of clauses (1) and (2); and

(6) are consistent with the Department of Human Services' policies related to covered services, flexibility of service use, and quality assurance.

(b) The commissioner must make training and guidance available to providers of services on the electronic visit verification requirements and system use.

(c) The commissioner must establish baseline measurements related to preventing fraud and establish measures to determine the effect of electronic visit verification requirements on program integrity.

(d) The commissioner must make a state-provided electronic visit verification system available to providers of services.

(e) The commissioner must make available and publish on the agency website the name and contact information for the vendor of the state-provided electronic visit verification system and the other vendors that offer alternative electronic visit verification systems. The information provided must state that the state-provided electronic visit verification system is offered at no cost to the provider of services and that the provider of services may choose an alternative system that may be at a cost to the provider.

(f) The commissioner may establish implementation dates and implementation schedules for system functions subject to electronic visit verification under this section, including but not limited to verification methods or technical requirements.

(g) The commissioner may waive the requirements under this section for any service component or setting when the application of electronic visit verification is contrary to paragraph (a).

Subd. 4. MS 2024 [Repealed, 2026 c 121 art 10 s 12]

Subd. 4a. **Electronic visit verification system options.** (a) A provider of services must use an electronic visit verification system that complies with the requirements established by the commissioner. A provider of services may use either the state-provided system or a third-party system. All systems used for compliance must provide data to the commissioner in the format and with the frequency required by the commissioner.

(b) The commissioner must make a state-provided electronic visit verification system available at no cost to providers of services. The commissioner must provide training on the system to all providers of services.

(c) The commissioner must allow providers of services to utilize a third-party electronic visit verification system that the commissioner determines meets the requirements under this section.

(d) A provider of services using a third-party electronic visit verification system that meets all technical specifications and federal and state laws must:

(1) collect and submit all data for each visit to the commissioner, including but not limited to manual entries;

(2) maintain compliance identified by the commissioner, including but not limited to incorporating into the system any changes in data requirements that must be transmitted to the commissioner; and

(3) integrate the system with the data aggregator to accurately send data.

(e) The data aggregator must be available at no cost to a provider of services for purposes of transmitting electronic visit verification data from approved third-party systems to the commissioner. Any costs associated with the development and use of a third-party system are the responsibility of the provider.

(f) If a provider is unable to integrate a third-party system with the data aggregator, the provider of services must use the state-provided electronic visit verification system.

(g) The commissioner must provide training on reviewing and correcting imported data in the data aggregator to providers of services.

Subd. 4b. **Provider responsibilities.** A provider of services must:

(1) use an electronic visit verification system that meets all technical and data submission requirements established by the commissioner;

(2) enroll with the state-provided electronic visit verification system or the data aggregator, as applicable;

(3) provide all information requested by the commissioner for enrollment, access, and data submission and ensure that the information remains accurate and up to date;

(4) maintain records for each individual receiving services subject to electronic visit verification, including but not limited to all required data elements;

(5) maintain a current list of workers providing services subject to electronic visit verification to individuals receiving services under medical assistance;

(6) provide the commissioner and any managed care organization with immediate, direct, and on-site or remote access to the electronic visit verification system;

(7) at the request of the commissioner or a managed care organization, allow review or copying of electronic visit verification documentation at no cost;

(8) ensure that electronic visit verification systems and related processes meet accessibility and confidentiality requirements under state and federal law;

(9) comply with all policies, procedures, and technical specifications issued by the commissioner under this section; and

(10) ensure that workers, participants, and other individuals using electronic visit verification are trained and comply with all documentation and data entry requirements established by the commissioner.

Subd. 5. **Vendor requirements.** (a) The vendor of the electronic visit verification system provided by the commissioner and the vendor's affiliate must comply with the requirements of this subdivision.

(b) The vendor of the state-provided electronic visit verification system and the vendor's affiliate must:

(1) notify the provider of services that the provider may choose the state-provided electronic visit verification system at no cost to the provider;

(2) offer the state-provided electronic visit verification system to the provider of services prior to offering any fee-based electronic visit verification system;

(3) notify the provider of services that the provider may choose any fee-based electronic visit verification system prior to offering the vendor's or its affiliate's fee-based electronic visit verification system; and

(4) when offering the state-provided electronic visit verification system, clearly differentiate between the state-provided electronic visit verification system and the vendor's or its affiliate's alternative fee-based system.

(c) The vendor of the state-provided electronic visit verification system and the vendor's affiliate must not use state data that are not available to other vendors of electronic visit verification systems to promote or sell the vendor's or its affiliate's alternative electronic visit verification system.

(d) Upon request from the provider, the vendor of the state-provided electronic visit verification system must provide proof of compliance with the requirements of paragraph (b).

(e) An agreement between the vendor of the state-provided electronic visit verification system or its affiliate and a provider of services for an electronic visit verification system that is not the state-provided system entered into on or after July 1, 2023, is subject to immediate termination by the provider if the vendor violates any of the requirements of paragraph (b).

Subd. 6. **Data and documentation.** (a) A provider of services must submit electronic visit verification data to the commissioner or the data aggregator in accordance with the technical standards, format, and frequency established under this section. The commissioner may use integrated electronic visit verification data for oversight, quality assurance, and program integrity purposes consistent with state and federal law.

(b) The commissioner and managed care organizations must use electronic visit verification data to validate claims for payment under medical assistance. Claims that cannot be validated in accordance with

electronic visit verification requirements may be subject to actions by the commissioner as authorized under state and federal law, including actions related to payment, program integrity, or provider compliance.

(c) A provider of services must record all required electronic visit verification data at the time of service delivery using an approved verification method. To be compliant with electronic visit verification requirements, a provider of services must document a visit with all required data elements recorded at the time of service delivery.

(d) A manual visit does not comply with electronic visit verification requirements. A manual visit must be confirmed and verified according to processes established by the commissioner before being used to validate or support a claim for payment.

(e) A worker providing services subject to electronic visit verification must record the start and end times of each visit at the time the service is delivered using an approved verification method. A worker must complete and verify all time documentation, including but not limited to verification of service type, date, and duration, on the date the service occurs and be consistent with documentation requirements of the service being provided. A provider of services must maintain documentation demonstrating compliance with this subdivision and make the documentation available to the commissioner or a managed care organization upon request.

Subd. 7. **Third-party system responsibilities.** (a) This subdivision is effective for Early Intensive Developmental and Behavioral Intervention services beginning July 1, 2027, or upon federal approval, whichever is later. This subdivision is effective for all other services subject to this subdivision beginning January 1, 2027, or upon federal approval, whichever is later.

(b) A provider of services using a third-party electronic visit verification system must ensure that the system meets all technical, functional, and data-exchange requirements established by the commissioner and transmits data to the commissioner or the data aggregator in the format and with the frequency required by the commissioner.

(c) A third-party electronic visit verification vendor must:

(1) comply with all technical, contractual, privacy, and security standards established by the commissioner;

(2) not use or disclose state data for any purpose other than fulfilling the requirements under this section or federal law;

(3) provide the commissioner access to system documentation, data mapping, and audit records upon request; and

(4) immediately report to the commissioner any data transmission failure, breach, or interruption affecting the commissioner's ability to receive required electronic visit verification data.

(d) A provider of services remains responsible for ensuring compliance with this section even when using a third-party electronic visit verification system.

(e) The third-party vendor must ensure training on the system is available to providers of services.

History: *1Sp2017 c 6 art 3 s 49; 1Sp2019 c 9 art 5 s 82,93; 2023 c 61 art 3 s 11,12; 2026 c 121 art 10 s 3-10*

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 recipients who are not enrolled in the prepaid medical assistance program 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 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. MS 2012 [Repealed, 2014 c 262 art 2 s 18]

Subd. 5. MS 2004 [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; 2016 c 158 art 2 s 91,92*

256B.0751 Subdivision 1. [Renumbered 62U.03, subd 2]

Subd. 2. [Renumbered 62U.03, subd 3]

Subd. 3. [Renumbered 62U.03, subd 4]

Subd. 4. [Renumbered 62U.03, subd 5]

Subd. 5. [Renumbered 62U.03, subd 6]

Subd. 6. [Renumbered 62U.03, subd 7]

Subd. 7. [Renumbered 62U.03, subd 8]

Subd. 8. [Renumbered 62U.03, subd 9]

Subd. 9. [Renumbered 62U.03, subd 10]

Subd. 10. [Renumbered 62U.03, subd 11]

256B.0752 MS 2018 [Repealed, 2020 c 115 art 3 s 40]

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 62U.03 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.

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; 2020 c 115 art 3 s 30,39*

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 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 INTEGRATED HEALTH PARTNERSHIP DEMONSTRATION PROJECT.

Subdivision 1. **Implementation.** (a) The commissioner shall continue a demonstration project established under this section to test alternative and innovative integrated health partnerships, 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 integrated health partnership 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 integrated health partnerships, and may be customized for the special needs and barriers of patient populations experiencing health disparities due to social, economic, racial, or ethnic factors;

(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 integrated health partnership and counties and nonprofit agencies that provide services to patients enrolled with the integrated health partnership, 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;

(9) establish a mechanism to monitor enrollment;

(10) establish quality standards for the integrated health partnerships that are appropriate for the particular patient population to be served; and

(11) encourage participation of privately insured population so as to create sufficient alignment in the integrated health partnership.

(c) To be eligible to participate in the demonstration project an integrated health partnership must:

(1) provide required covered services and care coordination to recipients enrolled in the integrated health partnership;

(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, telehealth, patient educators, care coordinators, and community health workers.

(d) An integrated health partnership 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).

An integrated health partnership 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 integrated health partnerships.

(e) The commissioner may require an integrated health partnership 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 an integrated health partnership.

(b) Eligible applicants and recipients may enroll in an integrated health partnership if the integrated health partnership serves the county in which the applicant or recipient resides. If more than one integrated health partnership serves a county, the applicant or recipient shall be allowed to choose among the integrated health partnerships. The commissioner may assign an applicant or recipient to an integrated health partnership if an integrated health partnership is available and no choice has been made by the applicant or recipient.

Subd. 3. **Accountability.** (a) Integrated health partnerships 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). Accountability standards must be appropriate to the particular population served.

(b) An integrated health partnership 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) An integrated health partnership 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 integrated health partnership must indicate how it will engage other providers, counties, and organizations, including county-based purchasing plans, that provide services to patients of the integrated health partnership on issues related to local population health, including applicable local needs, priorities, and public health goals. The integrated health partnership 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 integrated health partnerships, 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 an integrated health partnership.

(b) The payment system may include incentive payments to integrated health partnerships 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.

(d) The payment system shall include a population-based payment that supports care coordination services for all enrollees served by the integrated health partnerships, and is risk-adjusted to reflect varying levels of care coordination intensiveness for enrollees with chronic conditions, limited English skills, cultural differences, who are homeless, or who experience health disparities or other barriers to health care. The population-based payment shall be a per member, per month payment paid at least on a quarterly basis. Integrated health partnerships receiving this payment must continue to meet cost and quality metrics under the program to maintain eligibility for the population-based payment. An integrated health partnership is eligible to receive a payment under this paragraph even if the partnership is not participating in a risk-based or gain-sharing payment model and regardless of the size of the patient population served by the integrated health partnership. Any integrated health partnership participant certified as a health care home under section 62U.03 that agrees to a payment method that includes population-based payments for care coordination is not eligible to receive health care home payment or care coordination fee authorized under section 62U.03 or 256B.0753, subdivision 1, or in-reach care coordination under section 256B.0625, subdivision 56, for any medical assistance or MinnesotaCare recipients enrolled or attributed to the integrated health partnership under this demonstration.

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 integrated health partnership demonstration. As part of the demonstration expansion, the commissioner may procure the services of the integrated health partnerships authorized under this section by geographic area, to supplement or replace the services provided by managed care plans operating under section 256B.69.

Subd. 8. **Patient incentives.** The commissioner may authorize an integrated health partnership to provide incentives for patients to:

(1) see a primary care provider for an initial health assessment;

(2) maintain a continuous relationship with the primary care provider; and

(3) participate in ongoing health improvement and coordination of care activities.

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; 1Sp2017 c 6 art 4 s 40-43,66; 2019 c 50 art 1 s 73; 2020 c 115 art 3 s 39; 1Sp2021 c 7 art 6 s 28*

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 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.

(c) The commissioner shall establish health homes to serve populations with serious mental illness who meet the eligibility requirements described under subdivision 2. The health home services provided by health homes shall focus on both the behavioral and the physical health of these populations.

Subd. 2. **Eligible individual.** (a) The commissioner may elect to develop health home models in accordance with United States Code, title 42, section 1396w-4.

(b) An individual is eligible for health home services under this section if the individual is eligible for medical assistance under this chapter and has a condition that meets the definition of mental illness as described in section 245.462, subdivision 20, paragraph (a), or 245.4871, subdivision 15, clause (2). The commissioner shall establish criteria for determining continued eligibility.

Subd. 2a. **Discharge criteria.** (a) An individual may be discharged from behavioral health home services if:

(1) the behavioral health home services provider is unable to locate, contact, and engage the individual for a period of greater than three months after persistent efforts by the behavioral health home services provider; or

(2) the individual is unwilling to participate in behavioral health home services as demonstrated by the individual's refusal to meet with the behavioral health home services provider, or refusal to identify the individual's health and wellness goals or the activities or support necessary to achieve these goals.

(b) Before discharge from behavioral health home services, the behavioral health home services provider must offer a face-to-face meeting with the individual, the individual's identified supports, and the behavioral health home services provider to discuss options available to the individual, including maintaining behavioral health home services.

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. **Designated provider.** Health home services are voluntary and an eligible individual may choose any designated provider. The commissioner shall establish designated providers to serve as health homes and provide the services described in subdivision 3 to individuals eligible under subdivision 2. The commissioner shall apply for grants as provided under section 3502 of the Patient Protection and Affordable Care Act to establish health homes and provide capitated payments to designated providers. For purposes of this section, "designated provider" means a provider, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, or any other entity that is determined by the commissioner to be qualified to be a health home for eligible individuals. This determination must be based on documentation evidencing that the designated provider has the systems and infrastructure in place

to provide health home services and satisfies the qualification standards established by the commissioner in consultation with stakeholders and approved by the Centers for Medicare and Medicaid Services.

Subd. 4a. **Behavioral health home services provider requirements.** A behavioral health home services provider must:

(1) be an enrolled Minnesota Health Care Programs provider;

(2) provide a medical assistance covered primary care or behavioral health service;

(3) utilize an electronic health record;

(4) utilize an electronic patient registry that contains data elements required by the commissioner;

(5) demonstrate the organization's capacity to administer screenings approved by the commissioner for substance use disorder or alcohol and tobacco use;

(6) demonstrate the organization's capacity to refer an individual to resources appropriate to the individual's screening results;

(7) have policies and procedures to track referrals to ensure that the referral met the individual's needs;

(8) conduct a brief needs assessment when an individual begins receiving behavioral health home services. The brief needs assessment must be completed with input from the individual and the individual's identified supports. The brief needs assessment must address the individual's immediate safety and transportation needs and potential barriers to participating in behavioral health home services;

(9) conduct a health wellness assessment within 60 days after intake that contains all required elements identified by the commissioner;

(10) conduct a health action plan that contains all required elements identified by the commissioner. The plan must be completed within 90 days after intake and must be updated at least once every six months, or more frequently if significant changes to an individual's needs or goals occur;

(11) agree to cooperate with and participate in the state's monitoring and evaluation of behavioral health home services; and

(12) obtain the individual's consent to begin receiving behavioral health home services using a form approved by the commissioner.

Subd. 4b. **Behavioral health home services provider training and practice transformation requirements.** (a) The behavioral health home services provider must ensure that all staff delivering behavioral health home services receive adequate preservice and ongoing training, including:

(1) training approved by the commissioner that describes the goals and principles of behavioral health home services; and

(2) training on evidence-based practices to promote an individual's ability to successfully engage with medical, behavioral health, and social services to achieve the individual's health and wellness goals.

(b) The behavioral health home services provider must ensure that staff are capable of implementing culturally responsive services, as determined by the individual's culture, beliefs, values, and language as identified in the individual's health wellness assessment.

(c) The behavioral health home services provider must participate in the department's practice transformation activities to support continued skill and competency development in the provision of integrated medical, behavioral health, and social services.

Subd. 4c. **Behavioral health home services staff qualifications.** (a) A behavioral health home services provider must maintain staff with required professional qualifications appropriate to the setting.

(b) If behavioral health home services are offered in a mental health setting, the integration specialist must be a licensed nurse, as defined in section 148.171, subdivision 9.

(c) If behavioral health home services are offered in a primary care setting, the integration specialist must be a mental health professional who is qualified according to section 245I.04, subdivision 2.

(d) If behavioral health home services are offered in either a primary care setting or mental health setting, the systems navigator must be a mental health practitioner who is qualified according to section 245I.04, subdivision 4, or a community health worker as defined in section 256B.0625, subdivision 49.

(e) If behavioral health home services are offered in either a primary care setting or mental health setting, the qualified health home specialist must be one of the following:

(1) a mental health certified peer specialist who is qualified according to section 245I.04, subdivision 10;

(2) a mental health certified family peer specialist who is qualified according to section 245I.04, subdivision 12;

(3) a case management associate as defined in section 245.462, subdivision 4, paragraph (g), or 245.4871, subdivision 4, paragraph (j);

(4) a mental health rehabilitation worker who is qualified according to section 245I.04, subdivision 14;

(5) a community paramedic as defined in section 144E.28, subdivision 9;

(6) a peer recovery specialist as defined in section 245G.11, subdivision 8; or

(7) a community health worker as defined in section 256B.0625, subdivision 49.

[See Note.]

Subd. 4d. **Behavioral health home services delivery standards.** (a) A behavioral health home services provider must meet the following service delivery standards:

(1) establish and maintain processes to support the coordination of an individual's primary care, behavioral health, and dental care;

(2) maintain a team-based model of care, including regular coordination and communication between behavioral health home services team members;

(3) use evidence-based practices that recognize and are tailored to the medical, social, economic, behavioral health, functional impairment, cultural, and environmental factors affecting the individual's health and health care choices;

(4) use person-centered planning practices to ensure the individual's health action plan accurately reflects the individual's preferences, goals, resources, and optimal outcomes for the individual and the individual's identified supports;

(5) use the patient registry to identify individuals and population subgroups requiring specific levels or types of care and provide or refer the individual to needed treatment, intervention, or services;

(6) identify past and current treatment or services and identify potential gaps in care using a tool approved by the commissioner;

(7) deliver services consistent with the standards for frequency and face-to-face contact required by the commissioner;

(8) ensure that a diagnostic assessment is completed for each individual receiving behavioral health home services within six months of the start of behavioral health home services;

(9) deliver services in locations and settings that meet the needs of the individual;

(10) provide a central point of contact to ensure that individuals and the individual's identified supports can successfully navigate the array of services that impact the individual's health and well-being;

(11) have capacity to assess an individual's readiness for change and the individual's capacity to integrate new health care or community supports into the individual's life;

(12) offer or facilitate the provision of wellness and prevention education on evidenced-based curriculums specific to the prevention and management of common chronic conditions;

(13) help an individual set up and prepare for medical, behavioral health, social service, or community support appointments, including accompanying the individual to appointments as appropriate, and providing follow-up with the individual after these appointments;

(14) offer or facilitate the provision of health coaching related to chronic disease management and how to navigate complex systems of care to the individual, the individual's family, and identified supports;

(15) connect an individual, the individual's family, and identified supports to appropriate support services that help the individual overcome access or service barriers, increase self-sufficiency skills, and improve overall health;

(16) provide effective referrals and timely access to services; and

(17) establish a continuous quality improvement process for providing behavioral health home services.

(b) The behavioral health home services provider must also create a plan, in partnership with the individual and the individual's identified supports, to support the individual after discharge from a hospital, residential treatment program, or other setting. The plan must include protocols for:

(1) maintaining contact between the behavioral health home services team member, the individual, and the individual's identified supports during and after discharge;

(2) linking the individual to new resources as needed;

(3) reestablishing the individual's existing services and community and social supports; and

(4) following up with appropriate entities to transfer or obtain the individual's service records as necessary for continued care.

(c) If the individual is enrolled in a managed care plan, a behavioral health home services provider must:

(1) notify the behavioral health home services contact designated by the managed care plan within 30 days of when the individual begins behavioral health home services; and

(2) adhere to the managed care plan communication and coordination requirements described in the behavioral health home services manual.

(d) Before terminating behavioral health home services, the behavioral health home services provider must:

(1) provide a 60-day notice of termination of behavioral health home services to all individuals receiving behavioral health home services, the commissioner, and managed care plans, if applicable; and

(2) refer individuals receiving behavioral health home services to a new behavioral health home services provider.

Subd. 4e. **Behavioral health home services provider variances.** (a) The commissioner may grant a variance to specific requirements under subdivision 4a, 4b, 4c, or 4d for a behavioral health home services provider according to this subdivision.

(b) The commissioner may grant a variance if the commissioner finds that:

(1) failure to grant the variance would result in hardship or injustice to the applicant;

(2) the variance would be consistent with the public interest; and

(3) the variance would not reduce the level of services provided to individuals served by the organization.

(c) The commissioner may grant a variance from one or more requirements to permit an applicant to offer behavioral health home services of a type or in a manner that is innovative, if the commissioner finds that the variance does not impede the achievement of the criteria in subdivision 4a, 4b, 4c, or 4d and may improve the behavioral health home services provided by the applicant.

(d) The commissioner's decision to grant or deny a variance request is final and not subject to appeal.

Subd. 5. **Payments.** (a) The commissioner shall make payments to each designated provider for the provision of health home services described in subdivision 3 to each eligible individual under subdivision 2 that selects the health home as a provider. This paragraph expires on the date that paragraph (b) becomes effective.

(b) Effective January 1, 2026, or upon federal approval, whichever is later, the commissioner shall make payments to each designated provider for the provision of health home services described in subdivision 3, except for behavioral health services, to each eligible individual under subdivision 2 who selects the health home as a provider.

Subd. 5a. **Payments for behavioral health home services.** (a) For services rendered on or after January 1, 2026, or on or after the date of federal approval, whichever is later, and notwithstanding subdivision 5, the commissioner must implement a single statewide reimbursement rate for behavioral health home services under this section. The rate must be no less than $425 per member per month. The commissioner must adjust the reimbursement rate for behavioral health home services annually according to the change from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined using the Centers for Medicare and Medicaid Services Medicare Economic Index as forecasted in the fourth quarter of the calendar year before the rate year.

(b) The commissioner must review and update the behavioral health home services rate under paragraph (a) at least every four years. The updated rate must account for the average hours required for behavioral health home team members spent providing services and the Department of Labor prevailing wage for required behavioral health home team members. The updated rate must ensure that behavioral health home services rates are sufficient to allow providers to meet required certifications, training, and practice transformation standards; staff qualification requirements; and service delivery standards.

(c) Managed care plans and county-based purchasing plans must reimburse providers at an amount that is at least equal to the fee-for-service rate for services under this subdivision. The commissioner must monitor the effect of this rate increase on enrollee access to services under this subdivision. If for any contract year federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this paragraph. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this paragraph.

[See Note.]

Subd. 6. **Coordination.** The commissioner, to the extent feasible, shall ensure that the requirements and payment methods for designated providers developed under this section are consistent with the requirements and payment methods for health care homes established under sections 62U.03 and 256B.0753. The commissioner may modify requirements and payment methods under sections 62U.03 and 256B.0753 in order to be consistent with federal health home requirements and payment methods.

Subd. 7. MS 2012 [Repealed, 2014 c 262 art 2 s 18]

Subd. 8. **Evaluation and continued development.** (a) For continued certification under this section, health homes must meet process, outcome, and quality standards developed and specified by the commissioner. The commissioner shall collect data from health homes as necessary to monitor compliance with certification standards.

(b) The commissioner may contract with a private entity to evaluate patient and family experiences, health care utilization, and costs.

(c) The commissioner shall utilize findings from the implementation of behavioral health homes to determine populations to serve under subsequent health home models for individuals with chronic conditions.

History: *1Sp2010 c 1 art 22 s 2; 2015 c 71 art 11 s 31; 1Sp2019 c 9 art 6 s 58-66; 2020 c 115 art 3 s 39; 2021 c 30 art 17 s 79; 2023 c 70 art 9 s 33; 2024 c 127 art 62 s 41,42; 2025 c 38 art 8 s 59; 1Sp2025 c 3 art 8 s 18,19; 1Sp2025 c 9 art 4 s 47*

NOTE: The amendment to subdivision 4c by Laws 2025, First Special Session chapter 9, article 4, section 47, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2025, First Special Session chapter 9, article 4, section 47, the effective date.

NOTE: Subdivision 5a, as added by Laws 2025, First Special Session chapter 3, article 8, section 19, is effective on the later of the following: (1) federal approval of the medical assistance program changes in this subdivision; or (2) federal approval of all necessary federal waivers to implement the managed care organization assessment in Minnesota Statutes, section 256B.1976. The commissioner of human services

shall notify the revisor of statutes when federal approval is obtained. Laws 2025, First Special Session chapter 3, article 8, section 19, the effective date.

256B.0758 HEALTH CARE DELIVERY PILOT PROGRAM.

(a) The commissioner may establish a health care delivery pilot program to test alternative and innovative integrated health care delivery networks, including accountable care organizations or a community-based collaborative care network created by or including North Memorial Health Care. If required, the commissioner shall seek federal approval of a new waiver request or amend an existing demonstration pilot project waiver.

(b) Individuals eligible for the pilot program shall be individuals who are eligible for medical assistance under section 256B.055. The commissioner may identify individuals to be enrolled in the pilot program based on zip code or whether the individuals would benefit from an integrated health care delivery network.

(c) In developing a payment system for the pilot programs, the commissioner shall establish a total cost of care for the individuals enrolled in the pilot program that equals the cost of care that would otherwise be spent for these enrollees in the prepaid medical assistance program.

History: *2015 c 71 art 11 s 32*

256B.0759 SUBSTANCE USE DISORDER DEMONSTRATION PROJECT.

Subdivision 1. **Establishment.** The commissioner shall develop and implement a medical assistance demonstration project to test reforms of Minnesota's substance use disorder treatment system to ensure individuals with substance use disorders have access to a full continuum of high-quality care.

Subd. 2. MS 2024 [Repealed, 2026 c 95 art 5 s 40]

Subd. 3. **Provider standards.** (a) The following programs that receive payment for substance use disorder treatment services under section 256B.0625 must enroll as a Minnesota Health Care Programs provider, meet the requirements established by the commissioner, and certify that the program meets the applicable American Society of Addiction Medicine (ASAM) levels of care according to section 254B.19:

(1) nonresidential substance use disorder treatment programs and residential treatment programs licensed under chapter 245G as licensed substance use disorder treatment facilities;

(2) withdrawal management programs licensed under chapter 245F; and

(3) out-of-state residential substance use disorder treatment programs.

Programs that do not meet the requirements of this paragraph are ineligible for payment for services provided under section 256B.0625.

(b) Programs licensed by the commissioner as residential treatment programs according to section 245G.21 that (1) receive payment under this chapter, (2) are licensed as a hospital under sections 144.50 to 144.581, and (3) provide only ASAM level 3.7 medically monitored inpatient level of care are not required to certify the ASAM 3.7 level of care. If a program described in this paragraph provides any additional ASAM levels of care, the program must certify those levels of care according to section 254B.19. Programs meeting the criteria in this paragraph must submit evidence of providing the required level of care to the commissioner to be exempt from enrolling in the demonstration.

(c) Tribally licensed programs that otherwise meet the requirements of this subdivision may elect to participate in the demonstration project. The commissioner must consult with Tribal Nations to discuss participation in the substance use disorder demonstration project.

(d) Programs subject to this section must:

(1) deliver services in accordance with section 254B.19; and

(2) offer substance use disorder treatment services with medications for opioid use disorder on site or facilitate timely access to medications for opioid use disorder off site.

Subd. 4. **Provider payment rates.** (a) Providers must be reimbursed at rates according to section 254B.0505, subdivision 1.

(b) Effective January 1, 2021, and contingent on annual federal approval, managed care plans and county-based purchasing plans must reimburse providers of the substance use disorder services meeting the requirements of section 254B.19 that are employed by or under contract with the plan an amount that is at least equal to the fee-for-service base rate payment for the substance use disorder services described in paragraph (a). The commissioner must monitor the effect of this requirement on the rate of access to substance use disorder services and residential substance use disorder rates. Capitation rates paid to managed care organizations and county-based purchasing plans must reflect the impact of this requirement. This paragraph expires if federal approval is not received at any time as required under this paragraph.

(c) Effective July 1, 2021, contracts between managed care plans and county-based purchasing plans and providers to whom paragraph (b) applies must allow recovery of payments from those providers if, for any contract year, federal approval for the provisions of paragraph (b) is not received, and capitation rates are adjusted as a result. Payment recoveries must not exceed the amount equal to any decrease in rates that results from this provision.

(d) For substance use disorder services with medications for opioid use disorder under section 254B.0505, subdivision 1, clause (7), provided on or after January 1, 2021, payment rates must be increased by 20 percent over the rates in effect on December 31, 2020. Upon implementation of new rates according to section 254B.121, the 20 percent increase will no longer apply.

Subd. 5. MS 2024 [Repealed, 2026 c 95 art 5 s 40]

Subd. 6. MS 2022 [Repealed, 2023 c 61 art 4 s 28]

Subd. 7. **Public access.** The state shall post the final documents, for example, monitoring reports, close out report, approved evaluation design, interim evaluation report, and summative evaluation report, on the state's Medicaid website within 30 calendar days of approval by CMS.

Subd. 8. **Federal approval; demonstration project extension.** The commissioner shall seek a five-year extension of the demonstration project under this section and to receive enhanced federal financial participation.

Subd. 9. **Demonstration project evaluation work group.** Beginning October 1, 2021, the commissioner shall assemble a work group of relevant stakeholders, including but not limited to demonstration project participants and the Minnesota Association of Resources for Recovery and Chemical Health, that shall meet at least quarterly for the duration of the demonstration to evaluate the long-term sustainability of any improvements to quality or access to substance use disorder treatment services caused by participation in

the demonstration project. The work group shall also determine how to implement successful outcomes of the demonstration project once the project expires.

History: *1Sp2019 c 9 art 6 s 67; 2020 c 74 art 3 s 5,6; 1Sp2021 c 7 art 11 s 18-23; 2022 c 98 art 6 s 25; 2023 c 50 art 4 s 5; 2023 c 61 art 4 s 16; 2024 c 108 art 4 s 25,26; 1Sp2025 c 9 art 4 s 55; 2026 c 95 art 5 s 29,30*

256B.076 CASE MANAGEMENT SERVICES.

Subdivision 1. **Generally.** (a) It is the policy of this state to ensure that individuals on medical assistance receive cost-effective and coordinated care, including efforts to address the profound effects of housing instability, food insecurity, and other social determinants of health. Therefore, subject to federal approval, medical assistance covers targeted case management services as described in this section and sections 245.4711; 245.4881; 256B.0625, subdivisions 20 to 20b; 256B.0924; 256B.094; and 256F.10.

(b) The commissioner, in collaboration with Tribes, counties, providers, and individuals served, must propose further modifications to targeted case management services to ensure a program that complies with all federal requirements, delivers services in a cost-effective and efficient manner, creates uniform expectations for targeted case management services, addresses health disparities, and promotes person- and family-centered services.

(c) The commissioner may suspend, reduce, or terminate the reimbursement to a provider that does not meet the requirements of this section or section 245.4711; 245.4881; 256B.0625, subdivisions 20 and 20b; 256B.0924; 256B.094; or 256F.10. The county of financial responsibility, as determined under chapter 256G or, if applicable, the Tribal agency, is responsible for any federal disallowances. The county or Tribal agency may share the financial responsibility with the county's or Tribal agency's contracted vendors.

Subd. 2. **Rate setting.** (a) The commissioner must develop and implement a statewide rate methodology for any county that subcontracts targeted case management services to a vendor. The commissioner must publish the final draft of the proposed rate methodology at least 30 days prior to posting the state plan amendment for public comment and must take stakeholder feedback into consideration by providing an opportunity for the public to provide feedback on the proposed rate methodology. The commissioner must respond to comments received before the submission of the state plan amendment, explaining the commissioner's decisions regarding the responses and identifying any changes made in an effort to respond to public feedback. On January 1, 2022, or upon federal approval, whichever is later, a county must use this methodology for any targeted case management services paid by medical assistance and delivered through a subcontractor.

(b) In setting this rate, the commissioner must include the following:

(1) prevailing wages;

(2) employee-related expense factor;

(3) paid time off and training factors;

(4) supervision and span of control;

(5) distribution of time factor;

(6) administrative factor;

(7) absence factor;

(8) program support factor;

(9) caseload sizes as published by the commissioner; and

(10) culturally specific program factor as described in subdivision 3.

(c) A county may request that the commissioner authorize a rate based on a different caseload size when a subcontractor is assigned to serve individuals with needs, such as homelessness or specific linguistic or cultural needs, that significantly differ from other eligible populations. A county must include the following in the request:

(1) the number of clients to be served by a full-time equivalent staffer;

(2) the specific factors that require a case manager to provide a significantly different number of hours of reimbursable services to a client; and

(3) how the county intends to monitor caseload size and outcomes.

(d) The commissioner must adjust only the factor for caseload size in paragraph (b), clause (9), in response to a request under paragraph (c). The commissioner must not duplicate costs assumed by the culturally specific program factor in paragraph (b), clause (10), in response to a request under paragraph (c). With agreement of counties and in consultation with other stakeholders, the commissioner may introduce factors and adjustments other than those listed in paragraphs (b) and (c), subject to federal approval.

Subd. 3. **Culturally specific program.** (a) "Culturally specific program" means a targeted case management program that:

(1) ensures effective, equitable, comprehensive, and respectful quality care services that are responsive to individuals within a specific population's values, beliefs, practices, health literacy, preferred language, and other communication needs;

(2) is designed to address the unique needs of individuals who share a common language or racial, ethnic, or social background;

(3) is governed with significant input from individuals of the specific background that the program is designed to serve; and

(4) employs individuals to provide targeted case management, at least 50 percent of whom are of the specific background that the program is designed to serve.

(b) The culturally specific program factor in subdivision 2, paragraph (b), clause (10), adjusts the targeted case management rate for culturally specific programs to reflect the staffing and programmatic costs necessary to provide culturally specific targeted case management.

Subd. 4. **Case management provided under contract.** If a county agency provides case management under contracts with other individuals or agencies and the county agency utilizes a competitive proposal process for the procurement of contracted case management services, the competitive proposal process must include evaluation criteria to ensure that the county maintains a culturally responsive program for case management services adequate to meet the needs of the population of the county. For the purposes of this section, "culturally responsive program" means a case management services program that:

(1) ensures effective, equitable, comprehensive, and respectful quality care services that are responsive to individuals within a specific population's values, beliefs, practices, health literacy, preferred language, and other communication needs; and

(2) is designed to address the unique needs of individuals who share a common language or racial, ethnic, or social background.

Subd. 5. **County-provided fee-for-service rate setting and reconciliation.** (a) Effective January 1 of the implementation year determined in the joint governance agreement under subdivision 6, or upon federal approval, whichever is later, the commissioner must pay targeted case management services for which counties provide the nonfederal share of money and county staff provide the services on a fee-for-service basis according to the cost-based payment methodology in this subdivision and consistent with the federal regulations related to certified public expenditures. To receive federal reimbursement for these services, a county providing eligible targeted case management services must complete a federally approved cost report in accordance with section 256.01, subdivision 2, paragraph (o).

(b) The commissioner must reimburse submitted claims based on an interim rate and must determine a final rate on a calendar-year basis following completion of a cost report reconciliation. The commissioner must notify counties of the final rate and post final rates publicly.

(c) To appeal a final rate determined by the commissioner under paragraph (b), a county must submit a written appeal request to the commissioner within 60 days after the date the commissioner issued the final rate determination. The appeal request must specify the disputed items and the name and address of the person to contact regarding the appeal.

(d) The payment methodology under this section must only be used to reimburse allowable medical assistance costs. The county of financial responsibility, as determined under chapter 256G, is responsible for any federal disallowances.

(e) Upon implementation, the commissioner must base interim rates on data from the testing period. The commissioner must base subsequent interim rates for a calendar year on the most recently completed reconciliation. The commissioner must notify counties of the interim rate by June 30 each year and post interim rates publicly. If the commissioner is unable to notify the counties by June 30, the commissioner must notify each county in writing no later than June 30 that the new interim rate is delayed and must provide an estimate of when the new interim rate will be available.

(f) Payments to counties for targeted case management expenditures under this section must be made only from federal earnings from services provided under this section.

(g) Counties must submit all claims for targeted case management services described in this section using a 15-minute unit.

Subd. 6. **Testing and implementation.** The commissioners of human services and children, youth, and families; the Association of Minnesota Counties (AMC); and the Minnesota Association of County Social Service Administrators (MACSSA) must collaborate to establish a joint governance agreement. The joint governance agreement must:

(1) establish system functionality requirements to (i) meet the business needs of local agencies providing targeted case management services and (ii) comply with applicable state and federal regulations for the Social Services Information System (SSIS), SSIS's replacement, and adjacent systems and the targeted case management cost report under subdivision 5;

(2) establish a schedule for transition planning, including but not limited to fiscal impact assessment and training; and

(3) specify that the rate method established in subdivision 5 must not be implemented without both the completion of a required testing period of 12 calendar months and the express approval by the commissioners of human services and children, youth, and families; AMC; and MACSSA.

Subd. 7. **Managed care plan units and rates for mental health targeted case management.** The commissioner must ensure that the prepaid health plans providing covered health services for eligible persons pursuant to this chapter and section 256L.03, subdivisions 1a and 1b, reimburse counties at a rate that is at least equal to the fee-for-service rate described in subdivision 5 for targeted case management services provided to Minnesota health care program (MHCP) health plan enrollees covered by medical assistance. If, for any contract year, federal approval is not received for this subdivision, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this subdivision. Contracts between managed care plans and county-based purchasing plans and providers to whom this subdivision applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this subdivision. Payment recoveries must not exceed the amount equal to any increase in rates that results from this subdivision. This subdivision expires if federal approval is not received for this subdivision at any time. This subdivision does not obligate MHCP health plans to contract with counties for the provision of targeted case management services.

Subd. 8. **Targeted case management gap funding.** (a) For purposes of this subdivision, "unacceptable loss" means when a county's finalized amount of targeted case management federal reimbursement following the commissioner's reconciliation for a calendar year for targeted case management under subdivision 5 is less than 90 percent of the average federal reimbursement received by that county during the base calendar years determined in paragraph (c).

(b) The commissioner must pay targeted case management gap funding in the amount and time frame specified in paragraph (c) to an individual county for calendar years in which the county experiences an unacceptable loss.

(c) The base calendar years are the three calendar years immediately before the testing period of 12 calendar months determined under subdivision 6. In consultation with the county that experienced the unacceptable loss, the commissioner must make appropriate adjustments to base year amounts as needed to prevent the base amounts from being unduly influenced by onetime events, anomalies, or small changes that appear large compared to a narrow historical base. The commissioner must not make adjustments to the eight county human services agencies that received the greatest amount of targeted case management federal reimbursement during the base calendar years. For agencies other than the eight county human services agencies that received the greatest amount, the total of all adjustments for a given calendar year must not exceed two percent of statewide federal targeted case management federal reimbursement that calendar year.

(d) The commissioner must pay targeted case management gap funding to the applicable county in an amount equaling the difference between the finalized amount of targeted case management federal reimbursement after reconciliation for that calendar year and 90 percent of the average federal reimbursement received by that county during the base calendar years, including any adjustments under paragraph (c). The commissioner must pay the county within 90 days of completing the reconciliation under subdivision 5.

(e) Targeted case management gap funding is a forecasted program under section 16A.11.

History: *1Sp2021 c 7 art 11 s 24; 2024 c 125 art 1 s 12; 2024 c 127 art 46 s 12; 2026 c 121 art 3 s 48-52*

256B.0761 REENTRY DEMONSTRATION WAIVER.

Subdivision 1. **Establishment.** The commissioner must submit a waiver application to the Centers for Medicare and Medicaid Services to implement a medical assistance demonstration project to provide health care and coordination services that bridge to community-based services for individuals confined in state, local, or Tribal correctional facilities, or facilities located outside of the seven-county metropolitan area that have an inmate census with a significant proportion of Tribal members or American Indians, prior to community reentry. The demonstration must be designed to:

(1) increase continuity of coverage;

(2) improve access to health care services, including mental health services, physical health services, and substance use disorder treatment services;

(3) enhance coordination between Medicaid systems, health and human services systems, correctional systems, and community-based providers;

(4) reduce overdoses and deaths following release;

(5) decrease disparities in overdoses and deaths following release; and

(6) maximize health and overall community reentry outcomes.

Subd. 2. **Eligible individuals.** (a) Notwithstanding section 256B.055, subdivision 14, individuals are eligible to receive services under this demonstration if they are eligible under section 256B.055, subdivision 3a, 6, 7, 7a, 9, 15, 16, or 17, as determined by the commissioner in collaboration with correctional facilities, local governments, and Tribal governments. This paragraph expires upon the effective date of paragraph (b).

(b) Effective January 1, 2028, or upon federal approval, whichever is later, notwithstanding section 256B.0618, individuals are eligible to receive services under this demonstration if they are eligible under section 256B.055, subdivision 3a, 6, 7, 7a, 9, 15, 16, or 17, as determined by the commissioner in collaboration with correctional facilities, local governments, and Tribal governments.

Subd. 3. **Eligible correctional facilities.** (a) The commissioner's waiver application is limited to:

(1) three state correctional facilities to be determined by the commissioner of corrections, one of which must be the Minnesota Correctional Facility-Shakopee;

(2) four correctional facilities for adults licensed under section 241.021, subdivision 1, identified in coordination with the Minnesota Sheriffs' Association and the Association of Minnesota Counties; and

(3) one correctional facility owned and managed by a Tribal government or a facility located outside of the seven-county metropolitan area that has an inmate census with a significant proportion of Tribal members or American Indians.

(b) Additional facilities may be added to the waiver contingent on legislative authorization and appropriations.

Subd. 4. **Services and duration.** (a) Services must be provided 90 days prior to an individual's release date or, if an individual's confinement is less than 90 days, during the time period between a medical assistance eligibility determination and the release to the community.

(b) Facilities must offer the following services using either community-based or corrections-based providers:

(1) case management activities to address physical and behavioral health needs, including a comprehensive assessment of individual needs, development of a person-centered care plan, referrals and other activities to address assessed needs, and monitoring and follow-up activities;

(2) drug coverage in accordance with section 256B.0625, subdivision 13, including up to a 30-day supply of drugs upon release;

(3) substance use disorder comprehensive assessments according to section 254B.0505, subdivision 1, clause (2);

(4) treatment coordination services according to section 254B.0505, subdivision 1, clause (3);

(5) peer recovery support services according to sections 245I.04, subdivisions 18 and 19, and 254B.0505, subdivision 1, clause (4);

(6) substance use disorder individual and group counseling provided according to sections 245G.07, subdivision 1, paragraph (a), clause (1), and 254B.0501 to 254B.0507;

(7) mental health diagnostic assessments as required under section 245I.10;

(8) group and individual psychotherapy as required under section 256B.0671;

(9) peer specialist services as required under sections 245I.04 and 256B.0615;

(10) family planning and obstetrics and gynecology services;

(11) physical health well-being and screenings and care for adults and youth; and

(12) medications used for the treatment of opioid use disorder and nonmedication treatment services for opioid use disorder under section 245G.22.

(c) Services outlined in this subdivision must only be authorized when an individual demonstrates medical necessity or other eligibility as required under this chapter or applicable state and federal laws.

Subd. 5. **Provider requirements and standards.** (a) Service providers must adhere to applicable licensing and provider standards as required by federal guidance.

(b) Service providers must be enrolled to provide services under Minnesota health care programs.

(c) Services must be provided by eligible providers employed by the correctional facility or by eligible community providers under contract with the correctional facility.

(d) The commissioner must determine whether each facility is ready to participate in this demonstration based on a facility-submitted assessment of the facility's readiness to implement:

(1) prerelease medical assistance application and enrollment processes for inmates not enrolled in medical assistance coverage;

(2) the provision or facilitation of all required prerelease services for a period of up to 90 days prior to release;

(3) coordination among county and Tribal human services agencies and all other entities with a role in furnishing health care and supports to address health-related social needs;

(4) appropriate reentry planning, prerelease care management, and assistance with care transitions to the community;

(5) operational approaches to implementing certain Medicaid and CHIP requirements, including applications, suspensions, notices, fair hearings, and reasonable promptness for coverage of services;

(6) a data exchange process to support care coordination and transition activities; and

(7) reporting of all requested data to the commissioner of human services to support program monitoring, evaluation, oversight, and all financial data to meet reinvestment requirements.

(e) Participating facilities must detail reinvestment plans for all new federal Medicaid money expended for reentry services that were previously the responsibility of each facility and provide detailed financial reports to the commissioner.

Subd. 6. **Payment rates.** (a) Payment rates for services under this section that are approved under Minnesota's state plan agreement with the Centers for Medicare and Medicaid Services are equal to current and applicable state law and federal requirements.

(b) Case management payment rates are equal to rates authorized by the commissioner for relocation targeted case management under section 256B.0621, subdivision 10.

(c) Claims for covered drugs purchased through discount purchasing programs, such as the Federal Supply Schedule of the United States General Services Administration or the MMCAP Infuse program, must be no more than the actual acquisition cost plus the professional dispensing fee in section 256B.0625, subdivision 13e. Drugs administered to members must be billed on a professional claim in accordance with section 256B.0625, subdivision 13e, paragraph (e), and submitted with the actual acquisition cost for the drug on the claim line. Pharmacy claims must be submitted with the actual acquisition cost as the ingredient cost field and the dispensing fee in section 256B.0625, subdivision 13e, as the dispensing fee field on the claim with the basis of cost indicator of 08. Providers may establish written protocols for establishing or calculating the facility's actual acquisition drug cost based on a monthly, quarterly, or other average of the facility's actual acquisition drug cost through the discount purchasing program. A written protocol must not include an inflation, markup, spread, or margin to be added to the provider's actual purchase price after subtracting all discounts.

Subd. 7. **Reentry services working group.** (a) The commissioner of human services, in collaboration with the commissioner of corrections, must convene a reentry services working group to consider ways to improve the demonstration under this section and related policies for justice-involved individuals.

(b) The working group must be composed of balanced representation, including:

(1) people with lived experience; and

(2) representatives from:

(i) community health care providers;

(ii) the Minnesota Sheriffs' Association;

(iii) the Minnesota Association for County Social Service Administrators;

(iv) the Association of Minnesota Counties;

(v) the Minnesota Juvenile Detention Association;

(vi) the Office of Addiction and Recovery;

(vii) NAMI Minnesota;

(viii) the Minnesota Association of Resources for Recovery and Chemical Health;

(ix) Tribal Nations; and

(x) the Minnesota Alliance of Recovery Community Organizations.

(c) The working group must:

(1) advise on the waiver application, implementation, monitoring, evaluation, and reinvestment plans;

(2) recommend strategies to improve processes that ensure notifications of the individual's release date, current location, postrelease location, and other relevant information are provided to state, county, and Tribal eligibility systems and managed care organizations;

(3) consider the value of expanding, replicating, or adapting the components of the demonstration authorized under this section to additional populations;

(4) consider information technology and other implementation needs for participating correctional facilities; and

(5) recommend ideas to fund expanded reentry services.

History: *2024 c 125 art 3 s 12; 2024 c 127 art 48 s 12; 2025 c 38 art 4 s 39; 1Sp2025 c 9 art 4 s 55; 2026 c 121 art 6 s 18,19*

NOTE: This section, as added by Laws 2024, chapter 125, article 3, section 12; and Laws 2024, chapter 127, article 48, section 12, is effective upon federal approval, except subdivision 7 was effective July 1, 2024. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2024, chapter 125, article 3, section 12; and Laws 2024, chapter 127, article 48, section 12, the effective dates.

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 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 MS 1990 [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 long-term care consultation assessment and support planning, is also intended to prevent or delay institutional placements and to provide access to transition assistance after placement. Further, the goal of long-term care consultation services is to contain costs associated with unnecessary institutional admissions. Long-term care consultation services must be available to any person regardless of public program eligibility.

(b) 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.

(c) Long-term care consultation services must be coordinated with long-term care options counseling, long-term care options counseling at critical care transitions, the Disability Hub, and preadmission screening.

(d) A 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. MS 2021 Supp [Repealed, 2022 c 98 art 16 s 31]

Subd. 2. MS 2000 [Repealed, 1Sp2001 c 9 art 4 s 34]

Subd. 2a. MS 2000 [Repealed, 1Sp2001 c 9 art 4 s 34]

Subd. 2b. MS 2020 [Repealed, 2022 c 98 art 16 s 31]

Subd. 2c. MS 2020 [Repealed, 2022 c 98 art 16 s 31]

Subd. 3. MS 2020 [Repealed, 2022 c 98 art 16 s 31]

Subd. 3a. MS 2021 Supp [Repealed, 2022 c 98 art 16 s 31]

Subd. 3b. MS 2020 [Repealed, 2022 c 98 art 16 s 31]

Subd. 3c. MS 2020 [Renumbered 256.975, subd 7e]

Subd. 3d. MS 2020 [Renumbered 256.975, subd 7f]

Subd. 3e. MS 2020 [Renumbered 256.975, subd 7g]

Subd. 3f. MS 2021 Supp [Repealed, 2022 c 98 art 16 s 31]

Subd. 3g. MS 2020 [Repealed, 2022 c 98 art 16 s 31]

Subd. 4. MS 2000 [Repealed, 1Sp2001 c 9 art 4 s 34]

Subd. 4a. MS 2012 [Repealed, 2013 c 108 art 2 s 45]

Subd. 4b. MS 2012 [Repealed, 2013 c 108 art 2 s 45]

Subd. 4c. MS 2012 [Repealed, 2013 c 108 art 2 s 45]

Subd. 4d. MS 2020 [Repealed, 2022 c 98 art 16 s 31]

Subd. 4e. MS 2020 [Repealed, 2022 c 98 art 16 s 31]

Subd. 5. MS 2020 [Repealed, 2022 c 98 art 16 s 31]

Subd. 6. MS 2020 [Repealed, 2022 c 98 art 16 s 31]

Subd. 6a. MS 2014 [Repealed, 2015 c 78 art 6 s 32]

Subd. 7. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 8. MS 2000 [Repealed, 2001 c 161 s 58]

Subd. 9. MS 2000 [Repealed, 1Sp2001 c 9 art 4 s 34]

Subd. 10. **Definitions.** (a) For purposes of this section, the following definitions apply.

(b) "Available service and setting options" or "available options," with respect to the home and community-based waivers under chapter 256S and sections 256B.092 and 256B.49, means all services and settings defined under the waiver plan for which a waiver applicant or waiver participant is eligible.

(c) "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.

(d) "Cost-effective" means community services and living arrangements that cost the same as or less than institutional care. For an individual found to meet eligibility criteria for home and community-based service programs under chapter 256S or section 256B.49, "cost-effectiveness" has the meaning found in the federally approved waiver plan for each program.

(e) "Independent living" means living in a setting that is not controlled by a provider.

(f) "Informed choice" has the meaning given in section 256B.4905, subdivision 1a.

(g) "Lead agency" means a county administering or a Tribe or health plan under contract with the commissioner to administer long-term care consultation services.

(h) "Long-term care consultation services" means the activities described in subdivision 11.

(i) "Long-term care options counseling" means the services provided by sections 256.01, subdivision 24, and 256.975, subdivision 7, and also includes telephone assistance and follow-up after a long-term care consultation assessment has been completed.

(j) "Long-term care options counseling at critical care transitions " means the services provided under section 256.975, subdivision 7e.

(k) "Minnesota health care programs" means the medical assistance program under this chapter and the alternative care program under section 256B.0913.

(l) "Person-centered planning" is a process that includes the active participation of a person in the planning of the person's services, including in making meaningful and informed choices about the person's own goals, talents, and objectives, as well as making meaningful and informed choices about the services the person receives, the settings in which the person receives the services, and the setting in which the person lives.

(m) "Preadmission screening" means the services provided under section 256.975, subdivisions 7a to 7c.

Subd. 11. **Long-term care consultation services.** The following activities are included in long-term care consultation services:

(1) intake for and access to assistance in identifying services needed to maintain an individual in the most inclusive environment;

(2) transfer or referral to long-term care options counseling services for telephone assistance and follow-up after a person requests assistance in identifying community supports without participating in a complete long-term care consultation assessment;

(3) long-term care consultation assessments conducted according to subdivisions 17 to 21, 23, or 24, which may be completed in a hospital, nursing facility, intermediate care facility for persons with developmental disabilities (ICF/DDs), regional treatment center, or the person's current or planned residence;

(4) providing recommendations for and referrals to cost-effective community services that are available to the individual;

(5) providing recommendations for institutional placement when there are no cost-effective community services available;

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

(7) determining service eligibility for the following state plan services:

(i) personal care assistance services under section 256B.0625, subdivisions 19a and 19c;

(ii) consumer support grants under section 256.476; or

(iii) community first services and supports under section 256B.85;

(8) notwithstanding provisions in Minnesota Rules, parts 9525.0004 to 9525.0024, gaining access to the following services, including obtaining necessary diagnostic information to determine eligibility:

(i) relocation targeted case management services available under section 256B.0621, subdivision 2, clause (4);

(ii) case management services targeted to vulnerable adults or people with developmental disabilities under section 256B.0924; and

(iii) case management services targeted to people with developmental disabilities under Minnesota Rules, part 9525.0016;

(9) determining eligibility for semi-independent living services under section 252.275, including obtaining necessary diagnostic information;

(10) determining home and community-based waiver and other service eligibility as required under chapter 256S and sections 256B.0913, 256B.092, and 256B.49, including:

(i) level of care determination for individuals who need an institutional level of care as determined under subdivision 26;

(ii) appropriate referrals to obtain necessary diagnostic information; and

(iii) an eligibility determination for consumer-directed community supports;

(11) providing information about competitive employment, with or without supports, for school-age youth and working-age adults and referrals to the Disability Hub and Disability Benefits 101 to ensure that an informed choice about competitive employment can be made;

(12) providing information about independent living to ensure that an informed choice about independent living can be made;

(13) providing information about self-directed services and supports, including self-directed funding options, to ensure that an informed choice about self-directed options can be made;

(14) developing an individual's person-centered assessment summary; and

(15) providing access to assistance to transition people back to community settings after institutional admission.

Subd. 12. **Exception to use of MnCHOICES assessment; contracted assessors.** A lead agency that has not implemented MnCHOICES assessments and uses contracted assessors as of January 1, 2022, is not subject to the requirements of subdivisions 11, clauses (7) to (9); 13; 14, paragraphs (a) to (c); 16 to 21; 23; 24; and 29 to 31.

Subd. 13. **MnCHOICES assessor qualifications, training, and certification.** (a) The commissioner shall develop and implement a curriculum and an assessor certification process.

(b) MnCHOICES certified assessors must have received training and certification specific to assessment and consultation for long-term care services in the state and either:

(1) have at least an associate's degree in human services, or other closely related field;

(2) have at least an associate's degree in nursing with a public health nursing certificate, or other closely related field; or

(3) be a registered nurse.

(c) Certified assessors shall demonstrate best practices in assessment and support planning, including person-centered planning principles, and have a common set of skills that ensures consistency and equitable access to services statewide.

(d) Certified assessors must be recertified every three years.

(e) A Tribal Nation may establish the Tribal Nation's own education and experience qualifications for certified assessors.

[See Note.]

Subd. 14. **Use of MnCHOICES certified assessors required.** (a) Each lead agency shall use MnCHOICES certified assessors who have completed MnCHOICES training and the certification process determined by the commissioner in subdivision 13.

(b) Each lead agency must ensure that the lead agency has sufficient numbers of certified assessors to provide long-term consultation assessment and support planning within the timelines and parameters of the service.

(c) 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.

(d) Tribes and health plans under contract with the commissioner must provide long-term care consultation services as specified in the contract.

(e) A lead agency must provide the commissioner with an administrative contact for communication purposes.

(f) A lead agency may contract under this subdivision with any hospital licensed under sections 144.50 to 144.56 to conduct assessments of patients in the hospital on behalf of the lead agency when the lead agency has failed to meet its obligations under subdivision 17. The contracted assessment must be conducted

by a hospital employee who is a qualified, certified assessor. The hospital employees who perform assessments under the contract between the hospital and the lead agency may perform assessments in addition to other duties assigned to the employee by the hospital, except the hospital employees who perform the assessments under contract with the lead agency must not perform any waiver-related tasks other than assessments. Hospitals are not eligible for reimbursement under subdivision 33. The lead agency that enters into a contract with a hospital under this paragraph is responsible for oversight, compliance, and quality assurance for all assessments performed under the contract.

Subd. 15. **Long-term care consultation team.** (a) Each county board of commissioners shall establish a long-term care consultation team. Two or more counties may collaborate to establish a joint local long-term care consultation team or teams.

(b) Each lead agency shall establish and maintain a team of certified assessors qualified under subdivision 13. Each team member is responsible for providing consultation with other team members upon request. 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. The team of certified assessors must include, at a minimum:

(1) a social worker; and

(2) a public health nurse or registered nurse.

(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 coordinated service models as required in subdivision 1, paragraph (c).

Subd. 16. **MnCHOICES certified assessors; responsibilities.** (a) Certified assessors must use person-centered planning principles to conduct an interview that identifies what is important to the person; the person's needs for supports and health and safety concerns; and the person's abilities, interests, and goals.

(b) Certified assessors are responsible for:

(1) ensuring persons are offered objective, unbiased access to resources;

(2) ensuring persons have the needed information to support informed choice, including where and how they choose to live and the opportunity to pursue desired employment;

(3) determining level of care and eligibility for long-term services and supports;

(4) using the information gathered from the interview to develop a person-centered assessment summary that reflects identified needs and support options within the context of values, interests, and goals important to the person; and

(5) providing the person with an assessment summary of findings, support options, and agreed-upon next steps.

Subd. 17. **MnCHOICES assessments.** (a) A long-term care consultation team must begin an assessment of a person requesting long-term care consultation services or for whom long-term care consultation services were recommended, including an estimated timeline to full completion of the assessment, within 20 working days after the date on which an assessment was requested or recommended.

(b) Assessments must be conducted according to this subdivision and subdivisions 19 to 21, 23, 24, and 29 to 31.

(c) Lead agencies shall use certified assessors to conduct the assessment.

(d) For a person with complex health care needs, a public health or registered nurse from the team must be consulted.

(e) The lead agency must use the MnCHOICES assessment provided by the commissioner to complete a comprehensive, conversation-based, person-centered assessment. The assessment must include the health, psychological, functional, environmental, and social needs of the individual necessary to develop a person-centered assessment summary that meets the individual's needs and preferences.

(f) Except as provided in subdivision 24, an assessment must be conducted by a certified assessor in an in-person conversational interview with the person being assessed.

Subd. 18. **Exception to use of MnCHOICES assessments; long-term care consultation team visit; notice.** (a) Until statewide implementation of MnCHOICES assessments, the requirement under subdivision 17, paragraph (a), does not apply to an assessment of a person requesting personal care assistance services. The commissioner shall provide at least a 90-day notice to lead agencies prior to the effective date of statewide implementation.

(b) This subdivision expires upon statewide implementation of MnCHOICES assessments. The commissioner shall notify the revisor of statutes when statewide implementation has occurred.

Subd. 19. **MnCHOICES assessments; third-party participation.** (a) The person's legal representative, if any, must provide input during the assessment process and may do so remotely if requested.

(b) At the request of the person, other individuals may participate in the assessment to provide information on the needs, strengths, and preferences of the person necessary to complete the assessment and assessment summary. Except for legal representatives or family members invited by the person, a person participating in the assessment may not be a provider of service or have any financial interest in the provision of services.

(c) For a person assessed for elderly waiver customized living or adult day services under chapter 256S, 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 must notify the provider of the date by which to submit this information. This information must be provided to the person conducting the assessment prior to the assessment.

(d) For a person 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 that the person completed in consultation with someone who is known to the person and who has interaction with the person on a regular basis. The provider must submit the report at least 60 days before the end of the person's current service agreement. The certified assessor must consider the content of the submitted report prior to finalizing the person's assessment or reassessment.

Subd. 20. **MnCHOICES assessments; duration of validity.** (a) An assessment that is completed as part of an eligibility determination for multiple programs for the alternative care, elderly waiver, developmental disabilities, community access for disability inclusion, community alternative care, and brain injury waiver

programs under chapter 256S and sections 256B.0913, 256B.092, and 256B.49 is valid to establish service eligibility for no more than 365 days after the date of the assessment.

(b) The effective eligibility start date for programs in paragraph (a) can never be prior to the date of assessment. Notwithstanding retroactive medical assistance coverage of state plan services, the effective date of eligibility for programs included in paragraph (a) cannot be prior to the completion date of the most recent updated assessment.

Subd. 21. MS 2024 [Repealed, 2026 c 121 art 9 s 62]

[See Note.]

Subd. 22. **MnCHOICES reassessments.** (a) Prior to a reassessment, the certified assessor must review the person's most recent assessment.

(b) Reassessments must:

(1) be tailored using the professional judgment of the assessor to the person's known needs, strengths, preferences, and circumstances;

(2) provide information to support the person's informed choice and opportunities to express choice regarding activities that contribute to quality of life, as well as information and opportunity to identify goals related to desired employment, community activities, and preferred living environment;

(3) provide a review of the most recent assessment, the current support plan's effectiveness and monitoring of services, and the development of an updated person-centered assessment summary;

(4) verify continued eligibility, offer alternatives as warranted, and provide an opportunity for quality assurance of service delivery; and

(5) be conducted annually or as required by federal and state laws.

(c) The certified assessor and the individual responsible for developing the support plan must ensure the continuity of care for the person receiving services and complete the updated assessment summary and the updated support plan no more than 60 days after the reassessment visit.

(d) The commissioner shall develop mechanisms for providers and case managers to share information with the assessor to facilitate a reassessment and support planning process tailored to the person's current needs and preferences.

Subd. 23. **MnCHOICES reassessments; option for alternative and self-directed waiver services.** (a) At the time of reassessment, the certified assessor shall assess a person receiving waiver residential supports and services and currently residing in a setting listed in clauses (1) to (5) to determine if the person would prefer to be served in a community-living setting as defined in section 256B.492, subdivision 1, paragraph (b), or in a setting not controlled by a provider, or to receive integrated community supports as described in section 245D.03, subdivision 1, paragraph (c), clause (8). The certified assessor shall offer the person through a person-centered planning process the option to receive alternative housing and service options. This paragraph applies to those currently residing in a:

(1) community residential setting;

(2) licensed adult foster care home that is either not the primary residence of the license holder or in which the license holder is not the primary caregiver;

(3) family adult foster care residence;

(4) customized living setting; or

(5) supervised living facility.

(b) At the time of reassessment, the certified assessor shall assess each person receiving waiver day services to determine if that person would prefer to receive employment services as described in section 245D.03, subdivision 1, paragraph (c), clauses (5) to (7). The certified assessor shall describe to the person through a person-centered planning process the option to receive employment services.

(c) At the time of reassessment, the certified assessor shall assess each person receiving non-self-directed waiver services to determine if that person would prefer an available service and setting option that would permit self-directed services and supports. The certified assessor shall describe to the person through a person-centered planning process the option to receive self-directed services and supports.

[See Note.]

Subd. 24. **Remote reassessments.** (a) Assessments performed according to subdivisions 17 to 20 and 23 must be in person unless the assessment is a reassessment meeting the requirements of this subdivision. Remote reassessments conducted by interactive video or telephone may substitute for in-person reassessments.

(b) For services provided by the developmental disabilities waiver under section 256B.092, and the community access for disability inclusion, community alternative care, and brain injury waiver programs under section 256B.49, remote reassessments may be substituted for four consecutive reassessments if followed by an in-person reassessment.

(c) For services provided by alternative care under section 256B.0913, essential community supports under section 256B.0922, and the elderly waiver under chapter 256S, remote reassessments may be substituted for one reassessment if followed by an in-person reassessment.

(d) For personal care assistance provided under section 256B.0659 and community first services and supports provided under section 256B.85, remote reassessments may be substituted for two consecutive reassessments if followed by an in-person reassessment.

(e) A remote reassessment is permitted only if the lead agency provides informed choice and the person being reassessed or the person's legal representative provides informed consent for a remote assessment. Lead agencies must document that informed choice was offered.

(f) The person being reassessed, or the person's legal representative, may refuse a remote reassessment at any time.

(g) During a remote reassessment, if the certified assessor determines an in-person reassessment is necessary in order to complete the assessment, the lead agency shall schedule an in-person reassessment.

(h) All other requirements of an in-person reassessment apply to a remote reassessment, including updates to a person's support plan.

[See Note.]

Subd. 24a. MS 2025 Supp [Repealed, 2026 c 121 art 9 s 62]

Subd. 25. **Reassessments for Rule 185 case management.** Unless otherwise required by federal law, the county agency is not required to conduct or arrange for an annual needs reassessment by a certified

assessor for people receiving Rule 185 case management under Minnesota Rules, part 9525.0016. The case manager who works on behalf of the person to identify the person's needs and to minimize the impact of the disability on the person's life must instead develop a person-centered service plan based on the person's assessed needs and preferences. The person-centered service plan must be reviewed annually for persons with developmental disabilities who are receiving only case management services under Minnesota Rules, part 9525.0016, and who make an informed choice to decline an assessment under this section.

Subd. 25a. MS 2025 Supp [Repealed, 2026 c 121 art 9 s 62]

Subd. 26. **Determination of institutional level of care.** (a) The determination of need for 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.

(b) The determination of need for nursing facility level of care must be made based on criteria in section 144.0724, subdivision 11.

Subd. 27. **Transition assistance.** (a) Lead agency certified assessors shall provide transition 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.

(b) Transition assistance must include:

(1) assessment;

(2) referrals to long-term care options counseling under section 256.975, subdivision 7, for support plan implementation and to Minnesota health care programs, including home and community-based waiver services and consumer-directed options through the waivers; and

(3) referrals to programs that provide assistance with housing.

(c) Transition assistance must also include information about the Centers for Independent Living, Disability Hub, and other organizations that can provide assistance with relocation efforts and information about contacting these organizations to obtain their assistance and support.

(d) 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 available transition assistance;

(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. 28. **Transition assistance; nursing home residents under 65 years of age.** (a) Upon referral from the Senior LinkAge Line, individuals under 65 years of age who are admitted to nursing facilities on an emergency basis with only a telephone screening must receive an in-person assessment from the long-term

care consultation team member of the county in which the facility is located within the timeline established by the commissioner based on review of data.

(b) At the in-person assessment, the long-term care consultation team member or county case manager must:

(1) perform the activities required under subdivision 27; and

(2) present information about home and community-based options, including consumer-directed options, so the individual can make informed choices.

(c) 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 must describe the services needed to move the individual out of the facility and a timeline for the move that is designed to ensure a smooth transition to the individual's home and community.

(d) For individuals under 21 years of age, a screening interview that recommends nursing facility admission must be in person and approved by the commissioner before the individual is admitted to the nursing facility.

(e) An individual under 65 years of age residing in a nursing facility must receive an in-person 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 an in-person assessment at least once every 36 months for the same purposes.

(f) Notwithstanding subdivision 33, the commissioner may pay county agencies directly for in-person assessments for individuals under 65 years of age who are being considered for placement or residing in a nursing facility.

Subd. 29. **Support planning.** (a) The certified assessor and the individual responsible for developing the support plan must complete the assessment summary and the support plan no more than 60 calendar days after the assessment visit.

(b) The person or the person's legal representative must be provided with a written assessment summary within the timelines established by the commissioner, regardless of whether the person is eligible for Minnesota health care programs.

(c) For a person being assessed for elderly waiver services under chapter 256S, a provider who submitted information under subdivision 19, paragraph (c), must receive the final written support plan when available.

(d) The written support plan must include:

(1) a summary of assessed needs as defined in subdivision 17, paragraphs (e) and (f);

(2) the individual's options and choices to meet identified needs, including all available options for:

(i) case management services and providers;

(ii) employment services, settings, and providers;

(iii) living arrangements;

(iv) self-directed services and supports, including self-directed budget options; and

(v) service provided in a non-disability-specific setting;

(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.

(e) For a person determined eligible for state plan home care under subdivision 11, clause (7), the person or person's legal representative must also receive a copy of the home care service plan developed by the certified assessor.

Subd. 30. **Assessment and support planning; supplemental information.** The lead agency must give the person receiving long-term care consultation services 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 person;

(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 person 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 11, clauses (7) to (10);

(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 26 and regarding eligibility for all services and programs as defined in subdivision 11, clauses (7) to (10);

(9) the person's right to appeal the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 11, clauses (5), (7) to (10), and (15), and 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. The certified assessor must verbally communicate this appeal right to the person and must visually point out where in the document the right to appeal is stated; and

(10) documentation that available options for employment services, independent living, and self-directed services and supports were described to the person.

Subd. 31. **Assessment and support planning; right to final decision.** The person has the right to make the final decision:

(1) between institutional placement and community placement after the recommendations have been provided under subdivision 30, clause (1), except as provided in section 256.975, subdivision 7a, paragraph (d);

(2) between community placement in a setting controlled by a provider and living independently in a setting not controlled by a provider;

(3) between day services and employment services; and

(4) regarding available options for self-directed services and supports, including self-directed funding options.

Subd. 32. **Administrative activity.** (a) The commissioner shall:

(1) streamline the processes, including timelines for when assessments need to be completed;

(2) provide the services in this section;

(3) implement integrated solutions to automate the business processes to the extent necessary for support plan approval, reimbursement, program planning, evaluation, and policy development; and

(4) effective July 1, 2028, grant limited role-based access to a person's support plan in the MnCHOICES system to home and community-based service providers who have been designated as a provider for that person by a lead agency for the purpose of signing the person's support plan electronically and demonstrating that the provider has reviewed, understood, and agrees to deliver services as outlined in the plan.

(b) The commissioner shall work with lead agencies responsible for conducting long-term care consultation services to modify the MnCHOICES application and assessment policies to create efficiencies while ensuring federal compliance with medical assistance and long-term services and supports eligibility criteria.

Subd. 33. **Payment for long-term care consultation services.** (a) 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 11. 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.

(b) The county is accountable for meeting local objectives as approved by the commissioner in the biennial home and community-based services quality assurance plan. The county must document its compliance with the local objectives on a form provided by the commissioner.

(c) The state shall pay 81.9 percent of the nonfederal share as reimbursement to the counties.

Subd. 34. **Dashboard on assessment completions.** (a) The commissioner shall maintain a dashboard on the department's public website containing summary data on the completion of assessments under this section. The commissioner must update the dashboard at least twice per year.

(b) The dashboard must include:

(1) the total number of assessments performed since the previous reporting period, by lead agency;

(2) the total number of initial assessments performed since the previous reporting period, by lead agency;

(3) the total number of reassessments performed since the previous reporting period, by lead agency;

(4) the number and percentage of assessments completed within the required timeline, by lead agency;

(5) the average length of time to complete an assessment, by lead agency;

(6) summary data of the location in which the assessments were performed, by lead agency; and

(7) other information the commissioner determines is valuable to assess the capacity of lead agencies to complete assessments within the timelines prescribed by law.

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; 2009 c 79 art 8 s 32-38,40-43; 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 12,13,15; 2012 c 216 art 11 s 6-15; 2012 c 247 art 4 s 20; 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 262 art 5 s 6; 2014 c 275 art 1 s 59; 2014 c 291 art 9 s 5; 2015 c 78 art 6 s 10-13,31; 2016 c 163 art 3 s 8; 2017 c 40 art 1 s 69,70; 2017 c 90 s 17; 1Sp2017 c 6 art 1 s 13-18; art 2 s 11; art 3 s 8; 2019 c 54 art 2 s 22,23; 1Sp2019 c 9 art 5 s 43-47; 1Sp2020 c 2 art 4 s 2-5; art 5 s 97; 2021 c 30 art 12 s 2; 1Sp2021 c 7 art 6 s 17-19; art 13 s 15; 2022 c 98 art 4 s 35; art 14 s 21; art 16 s 1,5-28,30; 2023 c 50 art 1 s 24; 2023 c 61 art 1 s 17; 2024 c 108 art 1 s 14; 2024 c 125 art 1 s 13-16; 2024 c 127 art 46 s 13-16; 1Sp2025 c 9 art 2 s 12-21; 2026 c 88 art 1 s 125; 2026 c 95 art 4 s 16,17; 2026 c 121 art 9 s 17,18*

NOTE: The amendment to subdivision 13 by Laws 2025, First Special Session chapter 9, article 2, section 14, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2025, First Special Session chapter 9, article 2, section 14, the effective date.

NOTE: The amendment to subdivision 13 by Laws 2026, chapter 95, article 4, section 16, is effective upon federal approval. Laws 2026, chapter 95, article 4, section 16, the effective date.

NOTE: The repeal of subdivision 21 is effective January 1, 2027. The text may be viewed at MS 2025 in the statutes archives.

NOTE: The amendment to subdivision 23 by Laws 2023, chapter 50, article 1, section 24, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2023, chapter 50, article 1, section 24, the effective date.

NOTE: The amendment to subdivision 24 by Laws 2024, chapter 108, article 1, section 14, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2024, chapter 108, article 1, section 14, the effective date.

NOTE: The amendment to subdivision 24 by Laws 2025, First Special Session chapter 9, article 2, section 17, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2025, First Special Session chapter 9, article 2, section 17, the effective date.

256B.0912 MS 2000 [Repealed, 1Sp2001 c 9 art 3 s 76]

256B.0913 ALTERNATIVE CARE PROGRAM.

Subdivision 1. **Purpose and goals.** The purpose of the alternative care program is to provide funding for home and community-based services for elderly persons, in order to limit nursing facility placements.

The program is designed to support elderly persons in their desire to remain in the community as independently and as long as possible and to support informal caregivers in their efforts to provide care for elderly people. Further, the goals of the program are:

(1) to contain medical assistance expenditures by funding care in the community; and

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

Subd. 2. **Eligibility for services.** Alternative care services are available to Minnesotans age 65 or older who would be eligible for medical assistance within 135 days of admission to a nursing facility and subject to subdivisions 4 to 13.

Subd. 3. MS 2000 [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 is a citizen of the United States or a United States national;

(2) 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 26, but for the provision of services under the alternative care program;

(3) the person is age 65 or older;

(4) the person would be eligible for medical assistance within 135 days of admission to a nursing facility;

(5) 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;

(6) 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. For purposes of this clause, short-term home health and nursing care insurance under section 62A.70 does not constitute health or other third-party insurance;

(7) except for individuals described in clause (8), 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 256S.18. 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 256S.04, 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;

(8) for individuals assigned a case mix classification A as described under section 256S.18, with (i) no dependencies in activities of daily living, or (ii) 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, 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 256S.18. 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 (7) for case mix classification A;

(9) 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; and

(10) for a person participating in consumer-directed community supports, the person's monthly service limit must be equal to the monthly service limits in clause (7), except that a person assigned a case mix classification L must receive the monthly service limit for case mix classification A.

(b) 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.

(c) 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.

(d) 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.

(e) Alternative care funding is not available for a person whose income is greater than the maintenance needs allowance under section 256S.05, 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.** (a) Alternative care funding may be used for payment of costs of:

(1) adult day services and adult day services bath;

(2) home care;

(3) homemaker services;

(4) personal care;

(5) case management and conversion case management;

(6) respite care;

(7) specialized supplies and equipment;

(8) home-delivered meals;

(9) nonmedical transportation;

(10) nursing services;

(11) chore services;

(12) companion services;

(13) nutrition services;

(14) family caregiver training and education;

(15) coaching and counseling;

(16) telehome care to provide services in their own homes in conjunction with in-home visits;

(17) consumer-directed community supports;

(18) environmental accessibility and adaptations;

(19) transitional services; and

(20) 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.

(b) 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, except that when alternative care services receive federal financial participation under the 1115 waiver demonstration, funding shall be allocated in accordance with subdivision 17.

[See Note.]

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 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 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.

(d) Alternative care covers sign language interpreter services and spoken language interpreter services for recipients eligible for alternative care when the services are necessary to help deaf and hard-of-hearing recipients or recipients with limited English proficiency obtain covered services. Coverage for face-to-face spoken language interpreter services shall be provided only if the spoken language interpreter used by the enrolled health care provider is listed in the registry or roster established under section 144.058.

[See Note.]

Subd. 5b. MS 2006 [Repealed, 2007 c 147 art 7 s 76]

Subd. 5c. MS 2006 [Repealed, 2007 c 147 art 7 s 76]

Subd. 5d. MS 2006 [Repealed, 2007 c 147 art 7 s 76]

Subd. 5e. MS 2006 [Repealed, 2007 c 147 art 7 s 76]

Subd. 5f. MS 2006 [Repealed, 2007 c 147 art 7 s 76]

Subd. 5g. MS 2006 [Repealed, 2007 c 147 art 7 s 76]

Subd. 5h. MS 2006 [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. When the commissioner determines that an overpayment has been made by the state, the commissioner shall recover the overpayment.

(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 sections 256S.07 to 256S.09.

(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.

(c) The case manager is responsible for the cost-effectiveness of the alternative care individual 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 256S.18.

(d) Case manager responsibilities include those in section 256S.09, subdivision 2.

Subd. 8. **Requirements for individual support plan.** (a) The case manager shall implement the 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 support plan must meet the requirements in section 256S.10. The plan shall include any services prescribed by the individual's attending physician, advanced practice registered nurse, or physician assistant 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 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. MS 2012 [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, except that when alternative care services receive federal financial participation under the 1115 waiver demonstration, funding shall be allocated in accordance with subdivision 17.

(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, except that when alternative care services receive federal financial participation under the 1115 waiver demonstration, funding shall be allocated in accordance with subdivision 17.

(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 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, except that when alternative care services receive federal financial participation under the 1115 waiver demonstration, funding shall be allocated in accordance with subdivision 17.

(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, except that when alternative care services receive federal financial participation under the 1115 waiver demonstration, funding shall be allocated in accordance with subdivision 17. 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, except that when alternative care services receive federal financial participation under the 1115 waiver

demonstration, funding shall be allocated in accordance with subdivision 17. 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 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;

(4) a person has chosen to participate in a consumer-directed service plan; or

(5) a person is receiving temporary alternative care services.

(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 chapter 256S, shall be submitted by the lead agency as the home and community-based services quality assurance plan on a form provided by the commissioner.

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 256S.15.

Subd. 15. MS 1997 Supp [Repealed, 1998 c 407 art 4 s 69]

Subd. 15a. MS 2000 [Repealed, 1Sp2001 c 9 art 4 s 34]

Subd. 15b. MS 2000 [Repealed, 1Sp2001 c 9 art 4 s 34]

Subd. 15c. MS 2000 [Repealed, 1Sp2001 c 9 art 4 s 34]

Subd. 16. MS 2000 [Repealed, 1Sp2001 c 9 art 4 s 34]

Subd. 17. **Allocation under 1115 waiver demonstration.** When alternative care services receive federal financial participation under the 1115 waiver demonstration, alternative care funding shall be distributed in accordance with the projected demand for services based on service and financial eligibility. Discretionary alternative care services not listed in subdivision 5 or section 256B.0625 require approval from the commissioner.

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; 2015 c 71 art 6 s 3; 2015 c 78 art 6 s 14-21; 2019 c 54 art 2 s 24-28; 2020 c 115 art 4 s 129; 2022 c 58 s 150; 2022 c 98 art 17 s 11,26; 2023 c 61 art 2 s 4,5; 2024 c 85 s 68; 2024 c 125 art 2 s 12,13; 2024 c 127 art 47 s 12,13; 2026 c 124 art 1 s 54*

NOTE: The amendments to subdivisions 5 and 5a in Laws 2024, chapter 125, article 2, sections 12 and 13; and Laws 2024, chapter 127, article 47, sections 12 and 13, are effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2024, chapter 125, article 2, sections 12 and 13; and Laws 2024, chapter 127, article 47, sections 12 and 13, the effective dates.

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

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

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

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

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

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

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

(3) source selection plans;

(4) technical evaluations plans;

(5) technical evaluations of proposals;

(6) cost or price evaluation of proposals;

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) either:

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

(ii) be disqualified from further participation in the procurement until the bidder or offeror is no longer involved in that procurement, or all discussions with the bidder or offeror regarding possible employment have terminated without an arrangement for employment. A bidder or offeror may not engage in employment discussions with an official who is subject to this subdivision, until the bidder or offeror is no longer involved in that procurement.

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

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

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

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

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

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

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

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

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

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

Subd. 6. **Permanent restrictions on representation and communication.** (a) A person described in subdivision 2, after termination of 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

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

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

Subd. 13. **Civil penalties and injunctive relief.** (a) The Minnesota attorney general may bring a civil action in Ramsey county district court against a person who violates this section. Upon proof of such conduct by a preponderance of evidence, the person is subject to a civil penalty. An individual who violates this

section is subject to a civil penalty of not more than $50,000 for each violation plus twice the amount of compensation which the individual received or offered for the prohibited conduct. An organization that violates this section is subject to a civil penalty of not more than $500,000 for each violation plus twice the amount of compensation which the organization received or offered for the prohibited conduct.

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

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

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

(2) rescind the contract; or

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

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

(c) This section does not:

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

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

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

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

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

History: *1986 c 444; 1999 c 245 art 4 s 60; 2023 c 52 art 6 s 16*

256B.0915 Subdivision 1. MS 2018 [Repealed, 2019 c 54 art 1 s 34]

Subd. 1a. MS 2018 [Repealed, 2019 c 54 art 1 s 34]

Subd. 1b. MS 2018 [Repealed, 2019 c 54 art 1 s 34]

Subd. 1c. MS 2006 [Repealed by amendment, 2007 c 147 art 7 s 15]

Subd. 1d. MS 2018 [Repealed, 2019 c 54 art 1 s 34]

Subd. 2. MS 2018 [Repealed, 2019 c 54 art 1 s 34]

Subd. 3. MS 2018 [Repealed, 2019 c 54 art 1 s 34]

Subd. 3a. MS 2018 [Repealed, 1Sp2001 c 9 art 3 s 76; art 4 s 34; 2019 c 54 art 1 s 34]

Subd. 3b. MS 2018 [Repealed, 1Sp2001 c 9 art 3 s 76; art 4 s 34; 2019 c 54 art 1 s 34]

Subd. 3c. MS 2018 [Repealed, 1Sp2001 c 9 art 3 s 76; art 4 s 34; 2019 c 54 art 1 s 34]

Subd. 3d. MS 2018 [Repealed, 2019 c 54 art 1 s 34]

Subd. 3e. MS 2018 [Repealed, 2019 c 54 art 1 s 34]

Subd. 3f. MS 2018 [Repealed, 2019 c 54 art 1 s 34]

Subd. 3g. MS 2018 [Repealed, 2019 c 54 art 1 s 34]

Subd. 3h. MS 2018 [Repealed, 2019 c 54 art 1 s 34]

Subd. 3i. MS 2018 [Repealed, 2019 c 54 art 1 s 34]

Subd. 3j. MS 2018 [Repealed, 2019 c 54 art 1 s 34]

Subd. 4. MS 2018 [Repealed, 2019 c 54 art 1 s 34]

Subd. 5. MS 2018 [Repealed, 2019 c 54 art 1 s 34]

Subd. 6. MS 2018 [Repealed, 2019 c 54 art 1 s 34]

Subd. 7. MS 2018 [Repealed, 2019 c 54 art 1 s 34]

Subd. 8. MS 2018 [Repealed, 2019 c 54 art 1 s 34]

Subd. 9. MS 2018 [Repealed, 2019 c 54 art 1 s 34]

Subd. 10. MS 2018 [Repealed, 2019 c 54 art 1 s 34]

Subd. 11. MS 2018 [Repealed, 2019 c 54 art 1 s 34]

Subd. 12. MS 2018 [Repealed, 2019 c 54 art 1 s 34]

Subd. 13. MS 2018 [Repealed, 2019 c 54 art 1 s 34]

Subd. 14. MS 2018 [Repealed, 2019 c 54 art 1 s 34]

Subd. 15. MS 2018 [Repealed, 2019 c 54 art 1 s 34]

Subd. 16. MS 2018 [Repealed, 2019 c 54 art 1 s 34]

Subd. 17. [Uncodified, 2019 c 54 art 1 s 33]

256B.0916 EXPANSION OF HOME AND COMMUNITY-BASED SERVICES.

Subdivision 1. MS 2000 [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.

(f) The commissioner shall manage waiver allocations in such a manner as to fully use available state and federal waiver appropriations.

[See Note.]

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

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

[See Note.]

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.

[See Note.]

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.

[See Note.]

Subd. 6. MS 2012 [Repealed, 2014 c 262 art 4 s 9]

Subd. 6a. MS 2012 [Repealed, 2014 c 262 art 4 s 9]

Subd. 7. MS 2012 [Expired, 2012 c 216 art 9 s 23]

Subd. 8. **Financial and wait-list data reporting.** (a) The commissioner shall make available financial and waiting list information on the department's website.

(b) The financial information must include:

(1) the most recent end of session forecast available for the disability home and community-based waiver programs authorized under sections 256B.092 and 256B.49; and

(2) the most current financial information, updated at least monthly for the disability home and community-based waiver program authorized under section 256B.092 and three disability home and community-based waiver programs authorized under section 256B.49 for each county and Tribal agency, including:

(i) the amount of resources allocated;

(ii) the amount of resources authorized for participants; and

(iii) the amount of allocated resources not authorized and the amount not used as provided in subdivision 12, and section 256B.49, subdivision 27.

(c) The waiting list information must be provided quarterly beginning August 1, 2016, and must include at least:

(1) the number of persons screened and waiting for services listed by urgency category, the number of months on the wait list, age group, and the type of services requested by those waiting;

(2) the number of persons beginning waiver services who were on the waiting list, and the number of persons beginning waiver services who were not on the waiting list;

(3) the number of persons who left the waiting list but did not begin waiver services; and

(4) the number of persons on the waiting list with approved funding but without a waiver service agreement and the number of days from funding approval until a service agreement is effective for each person.

(d) By December 1 of each year, the commissioner shall compile a report posted on the department's website that includes:

(1) the financial information listed in paragraph (b) for the most recently completed allocation period;

(2) for the previous four quarters, the waiting list information listed in paragraph (c);

(3) for a 12-month period ending October 31, a list of county and Tribal agencies required to submit a corrective action plan under subdivisions 11 and 12, and section 256B.49, subdivisions 26 and 27; and

(4) for a 12-month period ending October 31, a list of the county and Tribal agencies from which resources were moved as authorized in section 256B.092, subdivision 12, and section 256B.49, subdivision 11a, the amount of resources taken from each agency, the counties that were given increased resources as a result, and the amounts provided.

[See Note.]

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 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. MS 2022 [Repealed, 2024 c 125 art 1 s 48; 2024 c 127 art 46 s 48]

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 for approval. The plan must state the actions the agency will take to correct their overspending for the two years following the period when the overspending occurred. The commissioner shall recoup spending in excess of the allocation only in cases where statewide spending exceeds the appropriation designated for the home and community-based services waivers. 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.

[See Note.]

Subd. 12. **Use of waiver allocations.** County and Tribal agencies are responsible for spending the annual allocation made by the commissioner. In the event a county or Tribal agency spends less than 97 percent of the allocation, while maintaining a list of persons waiting for waiver services, the county or Tribal agency must submit a corrective action plan to the commissioner for approval. The commissioner may determine a plan is unnecessary given the size of the allocation and capacity for new enrollment. The plan must state the actions the agency will take to assure reasonable and timely access to home and community-based waiver services for persons waiting for services. If a county or Tribe does not submit a plan when required or implement the changes required, the commissioner shall assure access to waiver services within the county's or Tribe's available allocation and take other actions needed to assure that all waiver participants in that county or Tribe are receiving appropriate waiver services to meet their needs.

[See Note.]

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; 2015 c 71 art 7 s 30-32; 2016 c 143 s 1*

NOTE: Subdivisions 2, 3, 4, 5, 8, 11, and 12 are repealed by Laws 2021, First Special Session chapter 7, article 13, section 79, effective upon federal approval. The commissioner of human services shall inform the revisor of statutes when federal approval is obtained. Laws 2021, First Special Session chapter 7, article 13, section 79.

256B.0917 ELDERCARE DEVELOPMENT PARTNERSHIPS.

Subdivision 1. MS 2012 [Repealed, 2013 c 108 art 2 s 45]

Subd. 1a. MS 2022 [Repealed, 2023 c 61 art 2 s 43]

Subd. 1b. **Definitions.** (a) For purposes of this section, the following terms have the meanings given.

(b) "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.

(c) "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.

(d) "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;

(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. MS 2012 [Repealed, 2013 c 108 art 2 s 45]

Subd. 3. MS 2012 [Repealed, 2013 c 108 art 2 s 45]

Subd. 4. MS 2012 [Repealed, 2013 c 108 art 2 s 45]

Subd. 5. MS 2012 [Repealed, 2013 c 108 art 2 s 45]

Subd. 6. MS 2022 [Repealed, 2023 c 61 art 2 s 43]

Subd. 7. MS 2012 [Repealed, 2013 c 108 art 2 s 45]

Subd. 7a. MS 2022 [Repealed, 2023 c 61 art 2 s 43]

Subd. 8. MS 2012 [Repealed, 2013 c 108 art 2 s 45]

Subd. 9. MS 2012 [Repealed, 2013 c 108 art 2 s 45]

Subd. 10. MS 2012 [Repealed, 2013 c 108 art 2 s 45]

Subd. 11. MS 2012 [Repealed, 2013 c 108 art 2 s 45]

Subd. 12. MS 2012 [Repealed, 2013 c 108 art 2 s 45]

Subd. 13. MS 2022 [Repealed, 2023 c 61 art 2 s 43]

Subd. 14. MS 2012 [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; 2019 c 54 art 2 s 29; 2023 c 61 art 2 s 6,42*

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 chapter 256S; waivered services under community access for disability inclusion 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. 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; 2015 c 78 art 6 s 31; 2019 c 54 art 2 s 30*

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 chapter 256S, 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.

Subd. 4. MS 2008 [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; 2019 c 54 art 2 s 31*

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 an assessment summary according to section 256B.0911, and authorize services identified in the person's 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 assessment summary 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 person-centered 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, including all service options available under the waiver plan;

(3) consulting with relevant medical experts or service providers;

(4) assisting the person in the identification of potential providers of chosen services, including:

(i) providers of services provided in a non-disability-specific setting;

(ii) employment service providers;

(iii) providers of services provided in settings that are not controlled by a provider; and

(iv) providers of financial management services;

(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 support plan, which must incorporate at least one annual face-to-face visit by the case manager with each person;

(8) reviewing support plans and providing the lead agency with recommendations for service authorization based upon the individual's needs identified in the support plan; and

(9) assisting and cooperating with facilities licensed under chapter 144G with the licensee's obligations under section 144G.55.

(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. If a county agency contracts for case management services, the county agency must provide each recipient of home and community-based services who is receiving contracted case management services with the contact information the recipient may use to file a grievance with the county agency about the quality of the contracted services the recipient is receiving from a county-contracted case manager. If a county agency provides case management under contracts with other individuals or agencies and the county agency utilizes a competitive proposal process for the procurement of contracted case management services, the competitive proposal process must include evaluation criteria to ensure that the county maintains a culturally responsive program for case management services adequate

to meet the needs of the population of the county. For the purposes of this section, "culturally responsive program" means a case management services program that: (1) ensures effective, equitable, comprehensive, and respectful quality care services that are responsive to individuals within a specific population's values, beliefs, practices, health literacy, preferred language, and other communication needs; and (2) is designed to address the unique needs of individuals who share a common language or racial, ethnic, or social background.

(d) 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 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 10.

(e) 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 person-centered support plan and habilitation plan.

(f) 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.

(g) The Department of Human Services shall offer ongoing education in case management to case managers. Case managers shall receive no less than 20 hours of case management education and disability-related training each year. The education and training must include appropriate service authorization, person-centered planning, informed choice, informed decision making, cultural competency, employment planning, community living planning, self-direction options, and use of technology supports. Case managers must annually complete an informed choice curriculum and pass a competency evaluation, in a form determined by the commissioner, on informed decision-making standards. By August 1, 2024, all case managers must complete an employment support training course identified by the commissioner of human services. For case managers hired after August 1, 2024, this training must be completed within the first six months of providing case management services. For the purposes of this section, "person-centered planning" or "person-centered" has the meaning given in section 256B.0911, subdivision 10. Case managers must document completion of training in a system identified by the commissioner.

Subd. 1b. **Support plan.** (a) Each recipient of home and community-based waivered services shall be provided a copy of the written person-centered support plan that:

(1) is developed with and signed by the recipient within the timelines established by the commissioner and section 256B.0911, subdivision 29;

(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;

(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, services and supports to achieve employment goals, and living arrangements;

(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 person-centered 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 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 person-centered 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. MS 1990 [Repealed, 1991 c 94 s 25; c 292 art 6 s 47]

Subd. 1d. MS 1990 [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 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 support plan;

(3) are consistent with other aspects of the 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 support plan is being followed according to paragraph (a);

(2) to identify any changes or modifications that might be needed in the 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 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 support plan.** Unless otherwise required by federal law, the county agency is not required to complete a 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;

(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. Except as provided in subdivision 3b, 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 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. 3a. **Authorization of technology services.** (a) Lead agencies must not implement additional requirements, in addition to those required by the commissioner, that could result in the delay of approval or implementation of technology.

(b) For individuals receiving waiver services under this section, approval or denial of technology must occur within 30 business days of the receipt of the initial request. If denied, the lead agency must submit a notice of action form clearly stating the reason for the denial, including information describing why the technology is not appropriate to meet the individual's assessed need.

Subd. 3b. **Service authorizations and service agreements.** (a) Recipients must be screened and authorized for services according to the federally approved waiver application and its subsequent amendments.

(b) The commissioner must require lead agency supervisors to review and accept all service agreements entered by lead agency staff into the Medicaid management information system (MMIS) prior to the commissioner's approval of the service agreement.

(c) For a service agreement with a proposed total authorized amount that exceeds the total authorized amount in the recipient's prior service agreement by more than the value of legislatively enacted rate increases, the commissioner must manually review and manually approve the service agreement in the MMIS. For purposes of this paragraph, "prior service agreement" means the service agreement that was in effect 12 months prior to the start date of the new proposed service agreement.

(d) In a format prescribed by the commissioner, lead agencies must submit the following information for all service agreements subject to the commissioner's approval in paragraph (c):

(1) changes in the number of units authorized;

(2) new services authorized;

(3) changes in the values used to calculate service rates under section 256B.4914, except for automatic adjustments required under section 256B.4914, subdivisions 5 and 5b;

(4) changes in the person's level of need that require an increase in the amount of services authorized;

(5) documentation detailing why the previous amount of services is not sufficient to meet the person's needs; and

(6) anticipated impact if the total service amount is not increased to the proposed amount.

(e) Except for rate increases required under section 256B.4914, subdivisions 5 and 5b, and rate changes authorized by the 2025 legislature, the commissioner must not approve service agreements under paragraph (c) that are not the result of either a documented change in a person's assessed needs or documented evidence that the previous level of service was insufficient to meet the person's assessed needs.

(f) This subdivision expires upon full implementation of waiver reimagine. The commissioner must inform the revisor of statutes when waiver reimagine is fully implemented.

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) The commissioner shall comply with the requirements in the federally approved transition plan for the home and community-based services waivers for the elderly authorized under this section.

[See Note.]

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 sections 14.055 and 14.056. 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. MS 2024 [Repealed, 2026 c 88 art 1 s 226]

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 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 1915(c) 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 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 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 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.

(d) The commissioner shall seek federal approval to allow for the reconfiguration of the 1915(c) home and community-based waivers in this section, as authorized under section 1915(c) of the federal Social Security Act, to implement a two-waiver program structure.

(e) The transition to two disability home and community-based services waiver programs must align with the independent living first policy under section 256B.4905. Unless superseded by any other state or federal law, waiver eligibility criteria shall be the same for each waiver. The waiver program that a person uses shall be determined by the support planning process and whether the person chooses to live in a provider-controlled setting or in the person's own home.

(f) Prior to July 1, 2024, the commissioner shall seek federal approval for the 1915(c) home and community-based waivers in this section, as authorized under section 1915(c) of the federal Social Security Act, to implement an individual resource allocation methodology.

[See Note.]

Subd. 5a. MS 2008 [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 developmental 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 support plan. The county where services are provided may not make changes in the person's 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) Assessment and support planning must be completed in accordance with requirements identified in section 256B.0911.

(c) No discharge shall take place until disputes are resolved under section 256.045, subdivision 4a, or until a review by the Direct Care and Treatment executive board 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.

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 access for disability inclusion, 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. Residential support services must be provided by vendors licensed as a community residential setting, 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 support plan; and

(3) the provider of residential support services must meet the requirements of licensure and additional requirements of the person's 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 7d, paragraph (c), are considered registered under this section.

Subd. 11a. **Residential support services criteria.** (a) For the purposes of this subdivision, "residential support services" means the following residential support services reimbursed under section 256B.4914: community residential services, customized living services, and 24-hour customized living services.

(b) In order to increase independent living options for people with disabilities and in accordance with section 256B.4905, subdivisions 7 and 8, and consistent with section 245A.03, subdivisions 7b to 7d, the commissioner must establish and implement criteria to access residential support services. The criteria for accessing residential support services must prohibit the commissioner from authorizing residential support services unless at least all of the following conditions are met:

(1) the individual has complex behavioral health or complex medical needs; and

(2) the individual's service planning team has considered all other available residential service options and determined that those options are inappropriate to meet the individual's support needs.

(c) Nothing in this subdivision shall be construed as permitting the commissioner to establish criteria prohibiting the authorization of residential support services for individuals described in the statewide priorities established in subdivision 12, the transition populations in subdivision 13, and the licensing moratorium exception criteria under section 245A.03, subdivision 7c.

(d) Individuals with active service agreements for residential support services on the date that the criteria for accessing residential support services become effective are exempt from the requirements of this subdivision, and the exemption from the criteria for accessing residential support services continues to apply for renewals of those service agreements.

Subd. 12. **Waiver 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 new enrollment resources to lead agencies, the commissioner must take into consideration the number of individuals waiting who meet statewide priorities.

[See Note.]

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 7c.

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 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 245I.24, subdivision 9; 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.

[See Note.]

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; 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; 2015 c 78 art 6 s 31; 2016 c 158 art 1 s 117; 2017 c 90 s 18; 1Sp2017 c 6 art 2 s 13; 1Sp2019 c 9 art 5 s 50; 1Sp2020 c 2 art 4 s 6,7; 1Sp2021 c 7 art 13 s 16-19; 2022 c 98 art 4 s 36; art 17 s 12,13,26; 2023 c 50 art 1 s 25; 2023 c 61 art 1 s 18; 2024 c 108 art 1 s 15; 2024 c 125 art 1 s 17; 2024 c 127 art 46 s 17; 2025 c 38 art 1 s 16,17; art 3 s 67; art 5 s 29; 1Sp2025 c 9 art 2 s 22-24; art 8 s 15; 2026 c 95 art 4 s 41; 2026 c 121 art 8 s 14*

NOTE: The amendment to subdivision 4 by Laws 2021, First Special Session chapter 7, article 13, section 16, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2021, First Special Session chapter 7, article 13, section 16, the effective date.

NOTE: The amendments to subdivisions 5 and 12 by Laws 2021, First Special Session chapter 7, article 13, sections 17 and 19, are effective 90 days after federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2021, First Special Session chapter 7, article 13, sections 17 and 19, the effective dates.

NOTE: The amendment to subdivision 14 by Laws 2026, chapter 121, article 8, section 14, is effective January 1, 2028. Laws 2026, chapter 121, article 8, section 17.

256B.0921 MS 2024 [Repealed, 2026 c 121 art 9 s 62]

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, subdivisions 17 to 21, 23, 24, or 27, 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 an assessment summary; and

(6) has been determined by a community assessment under section 256B.0911, subdivisions 17 to 21, 23, 24, or 27, 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 assessment summary.

(d) A person who has been determined to be eligible for essential community supports must be reassessed at least annually and continue to meet the criteria in paragraph (b) to remain eligible for essential community supports.

(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 chapter 256S or section 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 chapter 256S or section 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).

Subd. 3. **Billing limits.** (a) Effective January 1, 2027, or upon federal approval, whichever is later, billable unit maximums are established for the following services authorized under this section:

(1) for chore services, a maximum of 24 units per week per recipient, where a unit is defined as a 15-minute increment;

(2) for homemaker services, cleaning and home management may be provided for a maximum of 16 hours combined per week per recipient; and

(3) for personal emergency response system services, a maximum of one unit per month per recipient.

(b) Billing limits under this subdivision apply only to the individual service listed and do not prohibit the recipient from accessing other services for which they are eligible on the same day, week, or month, subject to other applicable requirements.

History: *2013 c 108 art 7 s 13; 2014 c 291 art 8 s 8; 2019 c 54 art 2 s 32; 2022 c 98 art 17 s 14,26; 2026 c 121 art 9 s 19*

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, 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 or Tribal 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) Except as permitted under paragraph (c), the person must be: (1) a vulnerable adult in need of adult protection as defined in section 626.5572; (2) an adult with a developmental disability as defined in section 252A.02, subdivision 2; (3) an adult with a related condition as defined in section 256B.02, subdivision 11, who is not receiving home and community-based waiver services; or (4) 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.

(c) Tribal agencies may make a determination of eligibility under Tribal governance codes for adult protection or policy procedures consistent with section 626.5572 when determining whether a person is a vulnerable adult in need of adult protection or an adult with developmental disabilities or a related condition.

[See Note.]

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;

(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. 4a. MS 2022 [Repealed, 1Sp2021 c 7 art 6 s 29]

Subd. 5. **Provider standards.** County boards, providers who contract with the county, or Tribal government contracted providers 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 services or Tribal human services agencies responsible for planning for community social services under chapters 256E and 256F; conducting adult protective investigations under section 626.557, and conducting prepetition screenings for commitments under section 253B.07;

(7) coordinate with health care providers to ensure access to necessary health care services;

(8) have a procedure in place that notifies the recipient and the recipient's legal representative of any conflict of interest if the contracted targeted case management service provider also provides the recipient's services and supports and provides information on all potential conflicts of interest and obtains the recipient's informed consent and provides the recipient with alternatives; and

(9) have demonstrated the capacity to achieve the following performance outcomes: access, quality, and consumer satisfaction.

[See Note.]

Subd. 5a. **Tribal case manager qualifications.** An individual is authorized to serve as a vulnerable adult and developmental disability targeted case manager if the individual is certified by a federally recognized Tribal government in Minnesota pursuant to section 256B.02, subdivision 7, paragraph (c).

Subd. 6. **Payment for targeted case management.** (a) The provider must meet the contact requirements under section 256B.094, subdivision 6. Contact by interactive video must meet the requirements in section 256B.0625, subdivision 20b, with the adult or the adult's legal representative, family, primary caregiver, or other relevant person identified as necessary to the development or implementation of the goals of the personal service plan.

(b) Except as provided under paragraph (m), payment for targeted case management provided by county staff under this subdivision must be based on the rate established in section 256B.076, subdivisions 5 and 7. 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 calculated in accordance with section 256B.076, subdivision 2. Payment for case management provided by vendors who contract with a Tribe must be made in accordance with Indian Health Service facility requirements. If a Tribe chooses to contract with a vendor receiving payment not through an Indian Health Service facility, the rate must be based on a monthly rate negotiated by the Tribe. The 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 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.

(d) If the service is provided by a team that includes any combination of contracted vendors, county staff, and Tribal 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 and Tribal case managers 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 the need for team targeted case management and a description of the different roles of staff.

(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. If the service is provided by a Tribal agency, the recipient's Tribe must provide the nonfederal share of costs, if any.

(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, or Tribe when applicable, 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 and Tribes 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 or Tribal payments for the cost of case management services provided by county or Tribal staff shall not be made to the commissioner of management and budget. For the purposes of targeted case management services provided by county or Tribal staff under this section, the centralized disbursement of payments to counties or Tribes 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 or Tribes.

(m) The commissioner may make payments for Tribes according to section 256B.0625, subdivision 34, or other relevant federally approved rate setting methodologies for vulnerable adult and developmental disability targeted case management provided by Indian health services and facilities operated by a Tribe or Tribal organization.

[See Note.]

Subd. 7. **Implementation and evaluation.** The commissioner of human services in consultation with county boards and Tribal Nations shall establish a program to accomplish the provisions of subdivisions 1 to 6. The commissioner in consultation with county boards and Tribal Nations shall establish performance measures to evaluate the effectiveness of the targeted case management services. If a county or Tribe fails to meet agreed-upon performance measures, the commissioner may authorize contracted providers other than the county or Tribe. 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; 1Sp2017 c 6 art 4 s 44; 1Sp2021 c 7 art 6 s 20; art 11 s 25; 2024 c 125 art 1 s 18; 2024 c 127 art 46 s 18; 1Sp2025 c 9 art 2 s 25; 2026 c 88 art 1 s 126; 2026 c 95 art 4 s 18-22; 2026 c 121 art 3 s 53*

NOTE: The amendment to subdivision 3 by Laws 2026, chapter 95, article 4, section 18, is effective upon federal approval. Laws 2026, chapter 95, article 4, section 18, the effective date.

NOTE: The amendment to subdivision 5 by Laws 2026, chapter 95, article 4, section 19, is effective upon federal approval. Laws 2026, chapter 95, article 4, section 19, the effective date.

NOTE: The amendment to subdivision 6 by Laws 2026, chapter 95, article 4, section 21, is effective upon federal approval. Laws 2026, chapter 95, article 4, section 21, the effective date.

256B.0925 MS 1994 [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 interdisciplinary team in Code of Federal Regulations, title 42, section 483.440. In addition, the admission review team must meet any conditions agreed to by the provider and the county where services are to be provided.

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

(1) a qualified 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 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 MS 2012 [Repealed, 2014 c 262 art 4 s 9]

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

Subdivision 1. **State traumatic brain injury program.** (a) 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; and

(6) investigate present and potential models of service coordination which can be delivered at the local level.

(b) The advisory committee required by paragraph (a), 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.

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 9505.0501 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;

(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 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; 2016 c 158 art 1 s 118; 2018 c 164 s 3; 2023 c 50 art 1 s 26*

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 available medical, social, educational, economic support, 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 available medical, social, educational, economic support, 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 based on the child's and family's or caregiver's current circumstances;

(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 managed care organization (MCO) or county-based purchasing (CBP) plan has contracted under section 256B.69 to provide medical and mental health services, the case management provider shall coordinate with the MCO or CBP plan to ensure that all necessary medical and mental health services required under the contract are provided to recipients of case management services.

(b) Child welfare targeted case management is carved out of Minnesota health care programs managed care contracts. The case management provider must assist the recipient to ensure access to all medically necessary services listed in section 256B.0625, whether delivered on a fee-for-service basis or by an MCO or CBP plan.

(c) 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 must be made in accordance with section 256B.076. Payment is based on face-to-face contacts either in person or by interactive video, 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 following requirements:

(1) there must be a face-to-face contact either in person or by interactive video that meets the requirements of section 256B.0625, subdivision 20b, 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, in-person contact.

(b) 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.

(c) Payment for case management provided by county contracted vendors must be calculated in accordance with section 256B.076, subdivision 2. Payment for case management provided by vendors who contract with a Tribe must be based on a monthly rate negotiated by the Tribe. The rate must not exceed the rate charged by the vendor for the same service to other payers. 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.

(d) 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.

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;

(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; 1Sp2021 c 7 art 6 s 21; art 11 s 26; 2026 c 121 art 3 s 54-56*

256B.0941 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY FOR PERSONS YOUNGER THAN 21 YEARS OF AGE.

Subdivision 1. **Eligibility.** (a) An individual who is eligible for mental health treatment services in a psychiatric residential treatment facility must meet all of the following criteria:

(1) before admission, services are determined to be medically necessary according to Code of Federal Regulations, title 42, section 441.152;

(2) is younger than 21 years of age at the time of admission. Services may continue until the individual meets criteria for discharge or reaches 22 years of age, whichever occurs first;

(3) has a mental health diagnosis as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders, as well as clinical evidence of severe aggression, or a finding that the individual is a risk to self or others;

(4) has functional impairment and a history of difficulty in functioning safely and successfully in the community, school, home, or job; an inability to adequately care for one's physical needs; or caregivers, guardians, or family members who are unable to safely fulfill the individual's needs;

(5) requires psychiatric residential treatment under the direction of a physician to improve the individual's condition or prevent further regression so that services will no longer be needed;

(6) utilized and exhausted other community-based mental health services, or clinical evidence indicates that such services cannot provide the level of care needed; and

(7) was referred for treatment in a psychiatric residential treatment facility by a mental health professional qualified according to section 245I.04, subdivision 2.

(b) The commissioner shall provide oversight and review the use of referrals for clients admitted to psychiatric residential treatment facilities to ensure that eligibility criteria, clinical services, and treatment planning reflect clinical, state, and federal standards for psychiatric residential treatment facility level of care. The commissioner shall coordinate the production of a statewide list of children and youth who meet the medical necessity criteria for psychiatric residential treatment facility level of care and who are awaiting admission. The commissioner and any recipient of the list shall not use the statewide list to direct admission of children and youth to specific facilities.

Subd. 2. **Services.** Psychiatric residential treatment facility service providers must offer and have the capacity to provide the following services:

(1) development of the individual plan of care, review of the individual plan of care every 30 days, and discharge planning by required members of the treatment team according to Code of Federal Regulations, title 42, sections 441.155 to 441.156;

(2) any services provided by a psychiatrist or physician for development of an individual plan of care, conducting a review of the individual plan of care every 30 days, and discharge planning by required members of the treatment team according to Code of Federal Regulations, title 42, sections 441.155 to 441.156;

(3) active treatment seven days per week that may include individual, family, or group therapy as determined by the individual care plan;

(4) individual therapy, provided a minimum of twice per week;

(5) family engagement activities, provided a minimum of once per week;

(6) consultation with other professionals, including case managers, primary care professionals, community-based mental health providers, school staff, or other support planners;

(7) coordination of educational services between local and resident school districts and the facility;

(8) 24-hour nursing; and

(9) direct care and supervision, supportive services for daily living and safety, and positive behavior management.

Subd. 2a. **Sleeping hours.** During normal sleeping hours, a psychiatric residential treatment facility provider must provide at least one staff person for every six residents present within a living unit. A provider must adjust sleeping-hour staffing levels based on the clinical needs of the residents in the facility. Sleeping hours must include at least one staff trained and certified to provide emergency medical response. During normal sleeping hours, a registered nurse must be available on call to assess a child's needs and must be available within 60 minutes.

Subd. 2b. **Shared site.** Related services that have a bright-line separation from psychiatric residential treatment facility service operations may be delivered in the same facility, including under the same structural roof. In shared site settings, staff must provide services only to programs they are affiliated to through NETStudy 2.0.

Subd. 3. **Per diem rate.** (a) The commissioner must establish one per diem rate per provider for psychiatric residential treatment facility services for individuals 21 years of age or younger. The rate for a provider must not exceed the rate charged by that provider for the same service to other payers. Payment must not be made to more than one entity for each individual for services provided under this section on a given day. The commissioner must set rates prospectively for the annual rate period. The commissioner must require providers to submit annual cost reports on a uniform cost reporting form and must use submitted cost reports to inform the rate-setting process. The cost reporting must be done according to federal requirements for Medicare cost reports.

(b) The following are included in the rate:

(1) costs necessary for licensure and accreditation, meeting all staffing standards for participation, meeting all service standards for participation, meeting all requirements for active treatment, maintaining medical records, conducting utilization review, meeting inspection of care, and discharge planning. The direct services costs must be determined using the actual cost of salaries, benefits, payroll taxes, and training of direct services staff and service-related transportation; and

(2) payment for room and board provided by facilities meeting all accreditation and licensing requirements for participation.

(c) A facility may submit a claim for payment outside of the per diem for professional services arranged by and provided at the facility by an appropriately licensed professional who is enrolled as a provider with Minnesota health care programs. Arranged services may be billed by either the facility or the licensed professional. These services must be included in the individual plan of care and are subject to prior authorization.

(d) Medicaid must reimburse for concurrent services as approved by the commissioner to support continuity of care and successful discharge from the facility. "Concurrent services" means services provided by another entity or provider while the individual is admitted to a psychiatric residential treatment facility. Payment for concurrent services may be limited and these services are subject to prior authorization by the state's medical review agent. Concurrent services may include targeted case management, assertive community treatment, clinical care consultation, team consultation, and treatment planning.

(e) Payment rates under this subdivision must not include the costs of providing the following services:

(1) educational services;

(2) acute medical care or specialty services for other medical conditions;

(3) dental services; and

(4) pharmacy drug costs.

(f) For purposes of this section, "actual cost" means costs that are allowable, allocable, reasonable, and consistent with federal reimbursement requirements in Code of Federal Regulations, title 48, chapter 1, part 31, relating to for-profit entities, and the Office of Management and Budget Circular Number A-122, relating to nonprofit entities.

(g) The commissioner shall annually adjust psychiatric residential treatment facility services per diem rates to reflect the change in the Centers for Medicare and Medicaid Services Inpatient Psychiatric Facility Market Basket. The commissioner shall use the indices as forecasted for the midpoint of the prior rate year to the midpoint of the current rate year.

Subd. 4. **Leave days.** (a) Medical assistance covers therapeutic and hospital leave days, provided the recipient was not discharged from the psychiatric residential treatment facility and is expected to return to the psychiatric residential treatment facility. A reserved bed must be held for a recipient on hospital leave or therapeutic leave.

(b) A therapeutic leave day to home shall be used to prepare for discharge and reintegration and shall be included in the individual plan of care. The state shall reimburse 75 percent of the per diem rate for a reserve bed day while the recipient is on therapeutic leave. A therapeutic leave visit may not exceed three days without prior authorization.

(c) A hospital leave day shall be a day for which a recipient has been admitted to a hospital for medical or acute psychiatric care and is temporarily absent from the psychiatric residential treatment facility. The state shall reimburse 50 percent of the per diem rate for a reserve bed day while the recipient is receiving medical or psychiatric care in a hospital.

Subd. 5. **Start-up and capacity-building grants.** (a) The commissioner shall establish start-up and capacity-building grants for psychiatric residential treatment facility sites. Start-up grants to prospective psychiatric residential treatment facility sites may be used for:

(1) administrative expenses;

(2) consulting services;

(3) Health Insurance Portability and Accountability Act of 1996 compliance;

(4) therapeutic resources, including evidence-based, culturally appropriate curriculums and training programs for staff and clients;

(5) allowable physical renovations to the property; and

(6) emergency workforce shortage uses, as determined by the commissioner.

(b) Start-up and capacity-building grants to prospective and current psychiatric residential treatment facilities may be used to support providers who treat and accept individuals with complex support needs, including but not limited to:

(1) neurocognitive disorders;

(2) co-occurring intellectual developmental disabilities;

(3) schizophrenia spectrum disorders;

(4) manifested or labeled aggressive behaviors; and

(5) manifested sexually inappropriate behaviors.

History: *1Sp2017 c 6 art 8 s 69; 1Sp2020 c 2 art 2 s 22,23; 2021 c 30 art 17 s 80; 2022 c 98 art 6 s 8; 2023 c 70 art 1 s 28; art 9 s 34-36; 2024 c 85 s 69*

256B.0943 CHILDREN'S THERAPEUTIC SERVICES AND SUPPORTS.

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

(b) "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 to treat a diagnosed mental illness, as defined in section 245.462, subdivision 20, or 245.4871, subdivision 15. 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.

(c) "Clinical trainee" means a staff person who is qualified according to section 245I.04, subdivision 6.

(d) "Crisis planning" 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 two or more individuals and individual or group skills training provided by a team, under the treatment supervision of a mental health professional.

(g) "Direct service time" means the time that a mental health professional, clinical trainee, mental health practitioner, or mental health behavioral aide spends face-to-face with a client and the client's family or providing covered services through telehealth as defined under section 256B.0625, subdivision 3b. Direct

service time includes time in which the provider obtains a client's history, develops a client's treatment plan, records individual treatment outcomes, 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 or maintaining clinical records.

(h) "Direction of mental health behavioral aide" means the activities of a mental health professional, clinical trainee, 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 individual treatment plan and meet the requirements in subdivision 6, paragraph (b), clause (7).

(i) "Individual treatment plan" means the plan described in section 245I.10, subdivisions 7 and 8.

(j) "Mental health behavioral aide services" means medically necessary one-on-one activities performed by a mental health behavioral aide qualified according to section 245I.04, subdivision 16, to assist a child retain or generalize psychosocial skills as previously trained by a mental health professional, clinical trainee, or mental health practitioner and as described in the child's individual treatment plan. Activities involve working directly with the child or child's family as provided in subdivision 9, paragraph (b), clause (4).

(k) "Mental health certified family peer specialist" means a staff person who is qualified according to section 245I.04, subdivision 12.

(l) "Mental health practitioner" means a staff person who is qualified according to section 245I.04, subdivision 4.

(m) "Mental health professional" means a staff person who is qualified according to section 245I.04, subdivision 2.

(n) "Mental health service plan development" includes:

(1) development and revision of a child's individual treatment plan; and

(2) administering and reporting standardized outcome measurements approved by the commissioner, as periodically needed to evaluate the effectiveness of treatment.

(o) "Mental illness" has the meaning given in section 245.462, subdivision 20, paragraph (a), for persons at least 18 years of age but under 21 years of age, and has the meaning given in section 245.4871, subdivision 15, for children under 18 years of age.

(p) "Psychotherapy" means the treatment described in section 256B.0671, subdivision 11.

(q) "Rehabilitative services" or "psychiatric rehabilitation services" means interventions to: (1) restore a child or adolescent to an age-appropriate developmental trajectory that had been disrupted by a psychiatric illness; or (2) enable the child to self-monitor, compensate for, cope with, counteract, or replace psychosocial skills deficits or maladaptive skills acquired over the course of a psychiatric illness. Psychiatric rehabilitation services for children combine coordinated psychotherapy to address internal psychological, emotional, and intellectual processing deficits, and skills training to restore personal and social functioning. Psychiatric rehabilitation services establish a progressive series of goals with each achievement building upon a prior achievement.

(r) "Skills training" means individual, family, or group training, delivered by or under the supervision 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 enable the child to self-monitor, compensate for, cope with, counteract, or replace

skills deficits or maladaptive skills acquired over the course of a psychiatric illness. Skills training is subject to the service delivery requirements under subdivision 9, paragraph (b), clause (2).

(s) "Standard diagnostic assessment" means the assessment described in section 245I.10, subdivision 6.

(t) "Treatment supervision" means the supervision described in section 245I.06.

[See Note.]

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 when the services are provided by an eligible provider entity licensed under section 245I.30 or children's day treatment services licensed under section 245I.31. The provider entity must make reasonable and good faith efforts to report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner.

(b) The covered service components of children's therapeutic services and supports are:

(1) the services described in section 245I.30, subdivision 2, provided by providers licensed under section 245I.30 or 245I.31;

(2) administration of standardized measures;

(3) direction of a mental health behavioral aide; and

(4) mental health service plan development.

(c) In delivering services under this section, a licensed provider entity must ensure that psychotherapy to address a child's underlying mental health disorder is documented as part of the child's ongoing treatment. A provider must deliver or arrange for medically necessary psychotherapy unless the child's parent or caregiver chooses not to receive the psychotherapy or the provider determines that psychotherapy is no longer medically necessary. When a provider determines that psychotherapy is no longer medically necessary, the provider must update required documentation, including but not limited to the individual treatment plan, the child's medical record, or other authorizations, to include the determination. When a provider determines that a child needs psychotherapy but psychotherapy cannot be delivered due to a shortage of licensed mental health professionals in the child's community, the provider must document the lack of access in the child's medical record.

(d) Medical assistance covers service plan development before completion of a child's individual treatment plan. Service plan development consists of development, review, and revision of the individual treatment plan by face-to-face or electronic communication, including time spent gathering client history from other key figures or providers. The provider must document events, including the time spent with the family and other key participants in the child's life to approve the individual treatment plan. Service plan development is covered only if a treatment plan is completed or for work already completed at the time the client voluntarily chooses to disengage with services for the child. If it is determined upon review that a treatment plan was not completed for the child, the commissioner shall recover the payment for the service plan development.

(e) Medical assistance covers time spent administering and reporting standardized measures approved by the commissioner.

[See Note.]

Subd. 3. **Determination of client eligibility.** (a) A client's eligibility to receive children's therapeutic services and supports under this section shall be determined based on a standard diagnostic assessment by a mental health professional or a clinical trainee that is performed within one year before the initial start of service and updated as required under section 245I.10, subdivision 2. The standard diagnostic assessment must:

(1) determine whether the person has a mental illness; and

(2) 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.

(b) Notwithstanding paragraph (a), a client may be determined to be eligible for up to five days of day treatment under this section based on a hospital's medical history and presentation examination of the client.

[See Note.]

Subd. 4. **Provider entity certification.** (a) 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. A provider entity must be certified for the three core rehabilitation services of psychotherapy, skills training, and crisis planning. The commissioner shall recertify a provider entity every three years using the individual provider's certification anniversary or the calendar year end, whichever is later. The commissioner may approve a recertification extension, in the interest of sustaining services, when a certain date for recertification is identified. The commissioner shall establish a process for decertification of a provider entity and shall require corrective action, medical assistance repayment, or decertification of a provider entity that no longer meets the requirements in this section or that fails to meet the clinical quality standards or administrative standards provided by the commissioner in the application and certification process.

(b) The commissioner must provide the following to providers for the certification, recertification, and decertification processes:

(1) a structured listing of required provider certification criteria;

(2) a formal written letter with a determination of certification, recertification, or decertification, signed by the commissioner or the appropriate division director; and

(3) a formal written communication outlining the process for necessary corrective action and follow-up by the commissioner, if applicable.

(c) For purposes of this section, a provider entity must meet the standards in this section and chapter 245I, as required under section 245I.011, subdivision 5, and 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.

[See Note.]

Subd. 5. **Provider entity administrative infrastructure requirements.** (a) An eligible provider entity shall demonstrate the availability, by means of employment or contract, of at least one backup mental health professional in the event of the primary mental health professional's absence.

(b) In addition to the policies and procedures required under section 245I.03, the policies and procedures must include:

(1) fiscal procedures, including internal fiscal control practices and a process for collecting revenue that is compliant with federal and state laws; and

(2) a client-specific treatment outcomes measurement system, including baseline measures, to measure a client's progress toward achieving mental health rehabilitation goals.

(c) A provider entity that uses a restrictive procedure with a client must meet the requirements of section 245.8261.

[See Note.]

Subd. 5a. **Background studies.** The requirements for background studies under section 245I.011, subdivision 5, paragraph (b), 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.

[See Note.]

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, individual 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 two years, must distribute the policies and procedures to staff initially and upon each subsequent update, and must train staff accordingly.

(b) The clinical infrastructure written policies and procedures must include policies and procedures for meeting the requirements in this subdivision:

(1) providing or obtaining a client's standard diagnostic assessment, including a standard diagnostic assessment. When required components of the standard diagnostic assessment are not provided in an outside or independent assessment or cannot be attained immediately, the provider entity must determine the missing information within 30 days and amend the child's standard diagnostic assessment or incorporate the information into the child's individual treatment plan;

(2) developing an individual treatment plan;

(3) providing treatment supervision plans for staff according to section 245I.06. Treatment supervision does not include the authority to make or terminate court-ordered placements of the child. A treatment supervisor must be available for urgent consultation as required by the individual client's needs or the situation;

(4) requiring a mental health professional to determine the level of supervision for a behavioral health aide and to document and sign the supervision determination in the behavioral health aide's supervision plan;

(5) ensuring the immediate accessibility of a mental health professional, clinical trainee, or mental health practitioner to the behavioral aide during service delivery;

(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 each of the goals and objectives in the 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.

[See Note.]

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 a:

(1) mental health professional;

(2) clinical trainee;

(3) mental health practitioner;

(4) mental health certified family peer specialist; or

(5) mental health behavioral aide.

(c) A day treatment team must include one mental health professional or clinical trainee.

[See Note.]

Subd. 8. MS 2020 [Repealed, 2021 c 30 art 17 s 113]

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.

[See Note.]

Subd. 9. **Service delivery criteria.** (a) In delivering services under this section, a certified provider entity must ensure that:

(1) 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;

(2) site-based programs, including day treatment 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; and

(3) a day treatment program is provided to a group of clients by a team under the treatment 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 remainder of the structured treatment program may include patient and/or family 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. When a day treatment group that meets the minimum group size requirement temporarily falls below the minimum group size because of a member's temporary absence, medical assistance covers a group session conducted for the group members in attendance.

(b) To be eligible for medical assistance payment, a provider entity must deliver the service components of children's therapeutic services and supports in compliance with the following requirements:

(1) psychotherapy to address the child's underlying mental health disorder must be documented as part of the child's ongoing treatment. A provider must deliver or arrange for medically necessary psychotherapy unless the child's parent or caregiver chooses not to receive it or the provider determines that psychotherapy is no longer medically necessary. When a provider determines that psychotherapy is no longer medically necessary, the provider must update required documentation, including but not limited to the individual treatment plan, the child's medical record, or other authorizations, to include the determination. When a provider determines that a child needs psychotherapy but psychotherapy cannot be delivered due to a shortage of licensed mental health professionals in the child's community, the provider must document the lack of access in the child's medical record;

(2) individual, family, or group skills training is subject to the following requirements:

(i) a mental health professional, clinical trainee, or mental health practitioner shall provide skills training;

(ii) skills training delivered to a child or the child's family 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;

(iii) 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:

(A) one mental health professional, clinical trainee, or mental health practitioner must work with a group of two to eight clients; or

(B) any combination of two mental health professionals, clinical trainees, or mental health practitioners must work with a group of nine to 12 clients;

(iv) a mental health professional, clinical trainee, or mental health practitioner must have taught the psychosocial skill before a mental health behavioral aide may practice that skill with the client; and

(v) for group skills training, when a skills group that meets the minimum group size requirement temporarily falls below the minimum group size because of a group member's temporary absence, the provider may conduct the session for the group members in attendance;

(3) crisis planning to a child and family must include development of a written plan that anticipates the particular factors specific to the child that may precipitate a psychiatric crisis for the child in the near future. The written plan must document actions that the family should be prepared to take to resolve or stabilize a crisis, such as advance arrangements for direct intervention and support services to the child and the child's family. Crisis planning must include preparing resources designed to address abrupt or substantial changes in the functioning of the child or the child's family when sudden change in behavior or a loss of usual coping mechanisms is observed, or the child begins to present a 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. To be eligible for medical assistance payment, mental health behavioral aide services must be delivered to a child who has been diagnosed with a mental illness, as provided in subdivision 1, paragraph (b). 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) mental health service plan development must be performed in consultation with the child's family and, when appropriate, with other key participants in the child's life by the child's treating mental health professional or clinical trainee or by a mental health practitioner and approved by the treating mental health professional. Treatment plan drafting consists of development, review, and revision by face-to-face or electronic communication. The provider must document events, including the time spent with the family and other key participants in the child's life to approve the individual treatment plan. Medical assistance covers service plan development before completion of the child's individual treatment plan. Service plan development is covered only if a treatment plan is completed for the child. If upon review it is determined that a treatment plan was not completed for the child, the commissioner shall recover the payment for the service plan development.

[See Note.]

Subd. 10. MS 2020 [Repealed, 2021 c 30 art 17 s 113]

Subd. 11. **Documentation and billing.** (a) A provider entity must document the services it provides under this section. The provider entity must ensure that documentation complies with Minnesota Rules, parts 9505.2175 and 9505.2197. Services billed under this section that are not documented according to this subdivision shall be subject to monetary recovery by the commissioner. Billing for covered service components under subdivision 2, paragraph (b), must not include anything other than direct service time.

(b) Required documentation must be completed for each individual provider and service modality for each day a child receives a service under subdivision 2, paragraph (b).

[See Note.]

Subd. 12. **Excluded services.** (a) 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, unless one service is delivered to the child and the other service is delivered to the child's family or treatment team without the child present;

(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 mental illness;

(iii) prevention or education programs provided to the community; and

(iv) treatment for clients with primary diagnoses of alcohol or other drug abuse.

(b) Time spent on administrative tasks before and after providing direct services, including scheduling or maintaining clinical records, is included in CTSS payments and may not be separately billed as additional clock hours of service.

[See Note.]

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 serious mental illness who is residing in a hospital; a residential treatment facility licensed under Minnesota Rules, parts 2960.0580 to 2960.0690; a psychiatric residential treatment facility under section 256B.0625, subdivision 45a; 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.

Subd. 14. **Treatment supervision limits.** (a) A treatment supervisor providing treatment supervision required by section 245I.06 must complete an attestation form in a manner provided by the commissioner. This form must be completed at least annually, and updated upon any change in the number of organizations the treatment supervisor is affiliated with under this section or section 256B.0623. The attestation must include:

(1) the total number of staff and full-time equivalent staff the treatment supervisor supervises, across all programs under this section and section 256B.0623, which must not exceed 20 full-time equivalent staff; and

(2) the name and national provider identifier of each organization for which the treatment supervisor provides supervision under this section or section 256B.0623, which must not exceed ten organizations.

(b) The commissioner may grant an exception to the limitations in paragraph (a), clauses (1) and (2). The commissioner must develop criteria and a standardized process for evaluating exception requests and

may rescind approval of an exception if the treatment supervisor fails to comply with applicable program standards.

Subd. 15. **Billing limits.** (a) Skills training under this section must not exceed two hours per day, three days per week per recipient. Prior authorization is required for services exceeding 200 hours per year.

(b) Mental health behavioral aide services under this section must not exceed six hours per day, three days per week per recipient. Prior authorization is required for services exceeding 200 hours per year.

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 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; 2015 c 78 art 2 s 4-12; 2017 c 79 s 6-8; 1Sp2017 c 5 art 10 s 7; 1Sp2017 c 6 art 10 s 7; 2018 c 128 s 8; 2021 c 30 art 17 s 81-90; 1Sp2021 c 7 art 6 s 22; 2022 c 55 art 1 s 131; 2022 c 98 art 6 s 9-15; 2023 c 25 s 141; 2024 c 85 s 70; 2024 c 127 art 61 s 24,25; 2025 c 38 art 8 s 60-64; 2026 c 88 art 1 s 127; 2026 c 95 art 5 s 31-34; 2026 c 121 art 6 s 20; art 7 s 49-51*

NOTE: Subdivisions 1, 4, 5, 5a, 6, 7, 9, and 11 are repealed by Laws 2026, chapter 121, article 7, section 55, effective January 1, 2028. Laws 2026, chapter 121, article 7, section 56.

NOTE: The amendments to subdivisions 2, 3, and 12 by Laws 2026, chapter 121, article 7, sections 49 to 51, are effective January 1, 2028. Laws 2026, chapter 121, article 7, section 56.

NOTE: Subdivision 8a is repealed by Laws 2022, chapter 98, article 6, section 26, effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2022, chapter 98, article 6, section 26, the effective date.

256B.0944 MS 2020 [Repealed, 2021 c 30 art 17 s 113]

256B.0945 SERVICES FOR CHILDREN WITH SERIOUS MENTAL ILLNESS.

Subdivision 1. **Residential services; provider qualifications.** (a) Counties must arrange to provide residential services for children with serious mental illness 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 626.557 or chapter 260E. 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. For residential facilities determined by the federal Centers for Medicare and Medicaid Services to be an institution for mental diseases, medical assistance covers medically necessary mental health services provided by the facility according to section 256B.055, subdivision 13, 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 under this section by a residential facility shall:

(1) for services provided by a residential facility that is not an institution for mental diseases, only be made of federal earnings for services provided, 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 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; and

(2) for services provided by a residential facility that is determined to be an institution for mental diseases, be equivalent to the federal share of the payment that would have been made if the residential facility were not an institution for mental diseases. The portion of the payment representing what would be the nonfederal shares shall be paid by the county. Payment to counties for services provided according to this section shall be a proportion of the per day contract rate that relates to rehabilitative mental health services and shall not include payment for costs or services that are billed to the IV-E program as room and board.

(b) 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. MS 2004 [Repealed, 2006 c 282 art 16 s 17]

Subd. 6. MS 2004 [Repealed, 2006 c 282 art 16 s 17]

Subd. 7. MS 2004 [Repealed, 2006 c 282 art 16 s 17]

Subd. 8. MS 2004 [Repealed, 2006 c 282 art 16 s 17]

Subd. 9. MS 2004 [Repealed, 2006 c 282 art 16 s 17]

Subd. 10. MS 2002 [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; 1Sp2017 c 6 art 8 s 71,72; 2019 c 12 s 1,2; 1Sp2019 c 9 art 6 s 74,75; 1Sp2020 c 2 art 8 s 92; 2025 c 38 art 8 s 65; 1Sp2025 c 9 art 9 s 6*

256B.0946 CHILDREN'S INTENSIVE BEHAVIORAL HEALTH SERVICES.

Subdivision 1. **Required covered service components.** (a) Subject to federal approval, medical assistance covers medically necessary intensive behavioral health treatment services when the services are provided by a provider entity certified under and meeting the standards in this section. The provider entity must make reasonable and good faith efforts to report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner.

(b) Intensive behavioral health treatment services to children with mental illness residing in foster family settings or with legal guardians that comprise specific required service components provided in clauses (1) to (6) are reimbursed by medical assistance when they meet the following standards:

(1) psychotherapy provided by a mental health professional or a clinical trainee;

(2) crisis planning;

(3) individual, family, and group psychoeducation services provided by a mental health professional or a clinical trainee;

(4) clinical care consultation provided by a mental health professional or a clinical trainee;

(5) individual treatment plan development as defined in section 245I.10, subdivisions 7 and 8; and

(6) 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) "At risk" means the child has experienced severe difficulty in managing mental health and behavior in multiple settings, has received a diagnosis of mental illness within the past 180 days, and meets one of the following criteria:

(1) has previously been in a residential or inpatient mental health treatment program, including a program licensed under Minnesota Rules, chapter 2960, for mental health issues within the past six months;

(2) has a history of threatening harm to self or others and has actively engaged in self-harming or threatening behavior in the past 30 days;

(3) has experienced interventions from mental health service programs, social services, mobile crisis programs, or law enforcement, or experienced the use of seclusion and restraints in school, to maintain safety in the child's home, community, or school within the past 60 days; or

(4) has a history of repeated intervention from mental health programs, social services, mobile crisis programs, or law enforcement to maintain safety in the child's home, community, or school within the past 60 days.

(b) "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.

(c) "Clinical trainee" means a staff person who is qualified according to section 245I.04, subdivision 6.

(d) "Crisis planning" has the meaning given in section 245.4871, subdivision 9a.

(e) "Culturally appropriate" means providing mental health services in a manner that incorporates the child's cultural influences into interventions as a way to maximize resiliency factors and utilize cultural strengths and resources to promote overall wellness.

(f) "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.

(g) "Standard diagnostic assessment" means the assessment described in section 245I.10, subdivision 6.

(h) "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.

(i) "Foster care" has the meaning given in section 260C.007, subdivision 18.

(j) "Foster family setting" means the foster home in which the license holder resides.

(k) "Individual treatment plan" means the plan described in section 245I.10, subdivisions 7 and 8.

(l) "Mental health certified family peer specialist" means a staff person who is qualified according to section 245I.04, subdivision 12.

(m) "Mental health professional" means a staff person who is qualified according to section 245I.04, subdivision 2.

(n) "Mental illness" has the meaning given in section 245I.02, subdivision 29.

(o) "Parent" has the meaning given in section 260C.007, subdivision 25.

(p) "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.

(q) "Psychotherapy" means the treatment described in section 256B.0671, subdivision 11.

(r) "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.

(s) "Trauma" has the meaning given in section 245I.02, subdivision 38.

(t) "Treatment supervision" means the supervision described under section 245I.06.

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, or placed in a foster home licensed under the regulations established by a federally recognized Minnesota Tribe, or who is residing in the legal guardian's home and is at risk, and has received: (1) a standard diagnostic assessment within 180 days before the start of service that documents that intensive behavioral health treatment services are medically necessary to ameliorate identified symptoms and functional impairments; and (2) a level of care assessment as defined in section 245I.02, subdivision 19, that demonstrates that the individual requires intensive intervention without 24-hour medical monitoring, and a functional assessment as defined in section 245I.02, subdivision 17. The level of care assessment and the functional assessment must include information gathered from the placing county, Tribe, or case manager.

Subd. 3. **Eligible mental health services providers.** (a) Eligible providers for children's intensive behavioral health services must be certified by the state and must be able to demonstrate the ability to provide all of the services required in this section and meet the standards in chapter 245I, as required in section 245I.011, subdivision 5.

(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 children's intensive behavioral health services, consistent with subdivision 1, paragraph (b), and comply with the following requirements in paragraphs (b) to (n).

(b) 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 standard diagnostic assessment and team consultation and treatment planning review process.

(c) 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.

(d) The level of care assessment as defined in section 245I.02, subdivision 19, and functional assessment as defined in section 245I.02, subdivision 17, must be updated at least every 180 days or prior to discharge from the service, whichever comes first.

(e) Each client receiving treatment services must have an individual treatment plan that is reviewed, evaluated, and approved every 180 days using the team consultation and treatment planning process.

(f) Clinical care consultation must be provided in accordance with the client's individual treatment plan.

(g) Each client must have a crisis 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.

(h) Services must be delivered and documented at least three days per week, equaling at least six hours of treatment per week. If the mental health professional, client, and family agree, service units may be temporarily reduced for a period of no more than 60 days in order to meet the needs of the client and family, or as part of transition or on a discharge plan to another service or level of care. The reasons for service reduction must be identified and documented in the treatment plan or case file. Billing and payment are prohibited for days on which no services are delivered and documented.

(i) 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.

(j) Treatment must be developmentally and culturally appropriate for the client.

(k) 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.

(l) Parents, siblings, foster parents, legal guardians, and members of the child's permanency plan must be involved in treatment and service delivery unless otherwise noted in the treatment plan.

(m) 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.

(n) In order for a provider to receive the daily per-client encounter rate, at least one of the services listed in subdivision 1, paragraph (b), clauses (1) to (3), must be provided. The services listed in subdivision 1, paragraph (b), clauses (4) and (5), may be included as part of the daily per-client encounter rate.

Subd. 5. MS 2020 [Repealed, 2021 c 30 art 17 s 113]

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 children's intensive behavioral health 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.0624;

(7) transportation; and

(8) mental health certified family peer specialist services under section 256B.0616.

(b) Children receiving intensive behavioral health services are not eligible for medical assistance reimbursement for the following services while receiving children's intensive behavioral health services:

(1) psychotherapy and skills training components of children's therapeutic services and supports under section 256B.0943;

(2) mental health behavioral aide services as defined in section 256B.0943, subdivision 1, paragraph (j);

(3) home and community-based waiver services;

(4) mental health residential treatment; and

(5) medical assistance room and board rate, as defined in section 256B.056, subdivision 5d.

Subd. 7. **Medical assistance payment and rate setting.** The commissioner shall establish a single daily per-client encounter rate for children's intensive behavioral health 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; 2015 c 78 art 2 s 13; 2018 c 128 s 10; 2021 c 30 art 17 s 91-96; 1Sp2021 c 7 art 11 s 27,28; 2022 c 98 art 4 s 37; 2022 c 99 art 1 s 17-23,48; 2023 c 50 art 4 s 7; 2023 c 70 art 9 s 37; art 17 s 45; 2025 c 38 art 8 s 66; 2026 c 95 art 5 s 35*

256B.0947 INTENSIVE REHABILITATIVE MENTAL HEALTH SERVICES.

Subdivision 1. **Scope.** Subject to federal approval, medical assistance covers medically necessary, intensive nonresidential rehabilitative mental health services when the services are provided by an entity meeting the standards in this section. The provider entity must make reasonable and good faith efforts to report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner.

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 who are eight years of age or older and under 21 years of age 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 use disorder" 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) "Standard diagnostic assessment" means the assessment described in section 245I.10, subdivision 6.

(d) "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.

(e) "Mental health professional" means a staff person who is qualified according to section 245I.04, subdivision 2.

(f) "Provider agency" means a for-profit or nonprofit organization established to administer an assertive community treatment for youth team.

(g) "Substance use disorders" means one or more of the disorders defined in the diagnostic and statistical manual of mental disorders, current edition.

(h) "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.

(i) "Treatment team" means all staff who provide services to recipients under this section.

(j) "Family peer specialist" means a staff person who is qualified under section 256B.0616.

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

(1) is eight years of age or older and under 21 years of age;

(2) is diagnosed with a serious mental illness or co-occurring mental illness and substance use disorder, for which intensive nonresidential rehabilitative mental health services are needed;

(3) has received a level of care assessment as defined in section 245I.02, subdivision 19, that indicates a need for intensive integrated intervention without 24-hour medical monitoring and a need for extensive collaboration among multiple providers;

(4) has received a functional assessment as defined in section 245I.02, subdivision 17, that indicates 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 during adulthood; and

(5) has had a recent standard diagnostic assessment 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) Intensive nonresidential rehabilitative mental health services, supports, and ancillary activities that are covered by a 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 (r);

(3) crisis planning as defined in section 245.4871, subdivision 9a;

(4) medication management provided by a qualified provider;

(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.0624;

(11) transition services;

(12) co-occurring substance use disorder treatment as defined in section 245I.02, subdivision 11; and

(13) housing access support that assists clients to 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.

(b) The provider shall ensure and document the following by means of performing the required function or by contracting with a qualified person or entity: client access to crisis intervention services, as defined in section 256B.0624, and available 24 hours per day and seven days per week.

[See Note.]

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 performance evaluation criteria for providers, including county providers, and may require applicants and providers to submit documentation as needed to allow the commissioner to determine whether the criteria are met.

Subd. 5. **Standards for intensive nonresidential rehabilitative providers.** (a) Services must meet the standards in this section and chapter 245I as required in section 245I.011, subdivision 5.

(b) The treatment team must have specialized training in providing services to the specific age group of youth that the team serves. An individual treatment team must serve youth who are: (1) at least eight years of age or older and under 16 years of age; (2) at least 14 years of age or older and under 21 years of age; or (3) if a treatment team demonstrates to the commissioner expertise in meeting the developmental and clinical needs of an expanded age range, at least eight years of age and under 21 years of age.

(c) 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) 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 minimally include:

(i) a mental health professional who serves as team leader to provide administrative direction and treatment supervision to the team;

(ii) a psychiatric care provider who is credentialed to prescribe medications and is either an advanced practice registered nurse with advanced education and training in psychiatric and mental health care or a board-certified psychiatrist. The psychiatric care provider must have demonstrated clinical experience and qualifications for working with children and adolescents with serious mental illness and co-occurring mental illness and substance use disorders;

(iii) a mental health certified peer specialist who is qualified according to section 245I.04, subdivision 10, and is also a former children's mental health consumer; and

(iv) a co-occurring disorder specialist who meets the requirements under section 256B.0622, subdivision 7a, paragraph (a), clause (4), who will provide or facilitate the provision of co-occurring disorder treatment to clients.

(2) The core team may also include any of the following:

(i) additional mental health professionals;

(ii) a vocational specialist;

(iii) an educational specialist 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;

(iv) a child and adolescent psychiatrist who may be retained on a consultant basis;

(v) a clinical trainee qualified according to section 245I.04, subdivision 6;

(vi) a mental health practitioner qualified according to section 245I.04, subdivision 4;

(vii) a case management service provider, as defined in section 245.4871, subdivision 4;

(viii) a housing access specialist;

(ix) a family peer specialist as defined in subdivision 2, paragraph (j); and

(x) a registered nurse, as defined in section 148.171, subdivision 20.

(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 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 use 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.

(d) The treatment 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 treatment 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.

(e) The staffing ratio must not exceed ten clients to one full-time equivalent treatment team position.

(f) 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.

(g) Nonclinical staff shall have prompt access in person or by telephone to a mental health practitioner, clinical trainee, 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 ensure the health and safety of clients.

(h) 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.

(i) A regional treatment team may serve multiple counties.

[See Note.]

Subd. 6. **Service standards.** The standards in this subdivision apply to intensive nonresidential rehabilitative mental health services.

(a) The treatment team must use team treatment, not an individual treatment model.

(b) Services must be available at times that meet client needs.

(c) Services must be age-appropriate and meet the specific needs of the client.

(d) The level of care assessment as defined in section 245I.02, subdivision 19, and functional assessment as defined in section 245I.02, subdivision 17, must be updated at least every six months or prior to discharge from the service, whichever comes first.

(e) The treatment team must complete an individual treatment plan for each client, according to section 245I.10, subdivisions 7 and 8, and the individual treatment plan must:

(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. For clients under the age of 18, the treatment team must consult with parents and guardians in developing the treatment plan;

(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;

(ii) develop a schedule for accomplishing substance use disorder treatment goals and objectives; and

(iii) identify the individuals responsible for providing substance use disorder treatment services and supports; and

(3) 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.

(f) 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.

(g) 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.

(h) 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.0624.

(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.

(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.

(e) Effective for the rate years beginning on and after January 1, 2024, rates must be annually adjusted for inflation using the Centers for Medicare and Medicaid Services Medicare Economic Index, as forecasted in the third quarter of the calendar year before the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined.

Subd. 7a. **Noncovered services.** (a) The rate for intensive rehabilitative mental health services does not include medical assistance payment for services in clauses (1) to (7). Services not covered under this paragraph may be billed separately:

(1) inpatient psychiatric hospital treatment;

(2) partial hospitalization;

(3) children's mental health day treatment services;

(4) physician services outside of care provided by a psychiatrist serving as a member of the treatment team;

(5) medical assistance room and board rate, as defined in section 256B.056, subdivision 5d;

(6) home and community-based waiver services; and

(7) other mental health services identified in the child's individualized education program.

(b) The following services are not covered under this section and are not eligible for medical assistance payment while youth are receiving intensive rehabilitative mental health services:

(1) mental health residential treatment; and

(2) mental health behavioral aide services, as defined in section 256B.0943, subdivision 1, paragraph (l).

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; 2015 c 78 art 2 s 14; 2016 c 158 art 1 s 119; 2016 c 163 art 2 s 6; 1Sp2020 c 2 art 2 s 25-28; 2021 c 30 art 13 s 55; art 17 s 97-103; 1Sp2021 c 7 art 11 s 29-31; 2022 c 55 art 1 s 132; 2022 c 58 s 151; 2022 c 98 art 4 s 38,39; art 6 s 16-18; 2023 c 25 s 142; 2023 c 70 art 1 s 29; art 17 s 46; 2024 c 127 art 55 s 12; art 61 s 26; 2025 c 38 art 8 s 67; 2026 c 95 art 5 s 36,37*

NOTE: The amendment to subdivision 3a by Laws 2026, chapter 95, article 5, section 36, is effective July 1, 2027, or upon federal approval, whichever is later. Laws 2026, chapter 95, article 5, section 36, the effective date.

NOTE: The amendment to subdivision 5, paragraph (c), clause (1), item (ii), by Laws 2026, chapter 95, article 5, section 37, is effective July 1, 2027, or upon federal approval, whichever is later. Laws 2026, chapter 95, article 5, section 37, the effective date.

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 EARLY INTENSIVE DEVELOPMENTAL AND BEHAVIORAL INTERVENTION BENEFIT.

Subdivision 1. **Purpose.** This section authorizes the early intensive developmental and behavioral intervention (EIDBI) benefit to provide early intensive intervention to a person with an autism spectrum disorder or a related condition. This benefit must provide coverage for a comprehensive, multidisciplinary evaluation, ongoing progress monitoring, and medically necessary early intensive treatment of autism spectrum disorder or a related condition. Nothing in this section shall preclude coverage for other medical assistance benefits based on a person's diagnosis of an autism spectrum disorder or a related condition, including, but not limited to, coverage under section 256B.0943 of children's therapeutic services and supports.

Subd. 2. **Definitions.** (a) The terms used in this section have the meanings given in this subdivision.

(b) "Advanced certification" means a person who has completed advanced certification in an approved modality under subdivision 13, paragraph (b).

(c) "Agency" means the legal entity that is enrolled with Minnesota health care programs as a medical assistance provider according to Minnesota Rules, part 9505.0195, to provide EIDBI services and that has the legal responsibility to ensure that its employees carry out the responsibilities defined in this section. Agency includes a licensed individual professional who practices independently and acts as an agency.

(d) "Autism spectrum disorder or a related condition" or "ASD or a related condition" means either autism spectrum disorder (ASD) as defined in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or a condition that is found to be closely related to ASD, as identified under the current version of the DSM, and meets all of the following criteria:

(1) is severe and chronic;

(2) results in impairment of adaptive behavior and function similar to that of a person with ASD;

(3) requires treatment or services similar to those required for a person with ASD; and

(4) results in substantial functional limitations in three core developmental deficits of ASD: social or interpersonal interaction; functional communication, including nonverbal or social communication; and restrictive or repetitive behaviors or hyperreactivity or hyporeactivity to sensory input; and may include deficits or a high level of support in one or more of the following domains:

(i) behavioral challenges and self-regulation;

(ii) cognition;

(iii) learning and play;

(iv) self-care; or

(v) safety.

(e) "Behavior analyst" means an individual licensed under sections 148.9981 to 148.9995 as a behavior analyst.

(f) "Clinical supervision" means the overall responsibility for the control and direction of EIDBI service delivery, including staff supervision, including observation and direction; individual treatment plan development and progress monitoring; family training and counseling; and coordinated care conference

coordination for each person. Clinical supervision is provided by a qualified supervising professional (QSP) who takes full professional responsibility for the service provided by each supervisee and the clinical effectiveness of all interventions.

(g) "Commissioner" means the commissioner of human services, unless otherwise specified.

(h) "Comprehensive multidisciplinary evaluation" or "CMDE" means a comprehensive evaluation of a person to determine medical necessity for EIDBI services based on the requirements in subdivision 5.

(i) "Department" means the Department of Human Services, unless otherwise specified.

(j) "Early intensive developmental and behavioral intervention benefit" or "EIDBI benefit" means a variety of individualized, intensive treatment modalities approved and published by the commissioner that are based in behavioral and developmental science consistent with best practices on effectiveness.

(k) "Employee of an agency" or "employee" means any individual who is employed temporarily, part time, or full time by the agency that is submitting claims or billing for the work, services, supervision, or treatment performed by the individual. Employee does not include an independent contractor, billing agency, or consultant who is not providing EIDBI services. Employee does not include an individual who performs work, provides services, supervises, or provides treatment for less than 80 hours in a 12-month period.

(l) "Generalizable goals" means results or gains that are observed during a variety of activities over time with different people, such as providers, family members, other adults, and people, and in different environments including, but not limited to, clinics, homes, schools, and the community.

(m) "Incident" means when any of the following occur:

(1) an illness, accident, or injury that requires first aid treatment;

(2) a bump or blow to the head; or

(3) an unusual or unexpected event that jeopardizes the safety of a person or staff, including a person leaving the agency unattended.

(n) "Individual treatment plan" or "ITP" means the person-centered, individualized written plan of care that integrates and coordinates person and family information from the CMDE for a person who meets medical necessity for the EIDBI benefit. An individual treatment plan must meet the standards in subdivision 6.

(o) "Legal representative" means the parent of a child who is under 18 years of age, a court-appointed guardian, or other representative with legal authority to make decisions about service for a person. For the purpose of this subdivision, "other representative with legal authority to make decisions" includes a health care agent or an attorney-in-fact authorized through a health care directive or power of attorney.

(p) "Mental health professional" means a staff person who is qualified according to section 245I.04, subdivision 2.

(q) "Person" means an individual under 21 years of age.

(r) "Person-centered" means a service that both responds to the identified needs, interests, values, preferences, and desired outcomes of the person or the person's legal representative and respects the person's history, dignity, and cultural background and allows inclusion and participation in the person's community.

(s) "Qualified EIDBI provider" means an individual who is a QSP or a level I, level II, or level III treatment provider.

Subd. 3. **EIDBI eligibility.** An EIDBI service is available to a person enrolled in medical assistance who:

(1) has a diagnosis of ASD or a related condition that meets the criteria of subdivision 4; and

(2) meets the criteria for medical necessity for the EIDBI benefit.

Subd. 3a. **Culturally and linguistically appropriate requirement.** The person's and family's primary spoken language and culture, values, goals, and preferences must be reflected throughout the covered services. The CMDE provider and QSP must determine how to adapt the evaluation, treatment recommendations, and individual treatment plan to the person's and family's culture, values, and language preferences. A provider must have a limited English proficiency (LEP) plan in compliance with title VI of the Civil Rights Act of 1964, United States Code, title 42, section 2000d to 2000d-7.

Subd. 4. **Diagnosis.** (a) A diagnosis of ASD or a related condition must:

(1) be based upon current DSM criteria including direct observations of the person and information from the person's legal representative or primary caregivers;

(2) be completed by either (i) a licensed physician, advanced practice registered nurse, or physician assistant, or (ii) a mental health professional; and

(3) meet the requirements of a standard diagnostic assessment according to section 245I.10, subdivision 6.

(b) Additional assessment information may be considered to complete a diagnostic assessment including specialized tests administered through 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. A diagnostic assessment may include treatment recommendations.

Subd. 5. **Comprehensive multidisciplinary evaluation.** (a) A CMDE must be completed to determine medical necessity of EIDBI services. For the commissioner to authorize EIDBI services, the CMDE provider must submit the CMDE to the commissioner and the person or the person's legal representative as determined by the commissioner. Information and assessments must be performed, reviewed, and relied upon for the eligibility determination, treatment and services recommendations, and treatment plan development for the person.

(b) The CMDE provider must review the diagnostic assessment to confirm the person has an eligible diagnosis and the diagnostic assessment meets standards required under subdivision 4. If the CMDE provider elects to complete the diagnostic assessment at the same time as the CMDE, the CMDE provider must certify that the CMDE meets all standards as required under subdivision 4.

(c) The CMDE must:

(1) include an assessment of the person's developmental skills, functional behavior, needs, and capacities based on direct observation of the person which must be administered by a CMDE provider, include medical or assessment information from the person's physician, advanced practice registered nurse, or physician assistant, and may also include input 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 or habilitation therapists, licensed school personnel, or mental health professionals;

(2) include and document the person's legal representative's or primary caregiver's preferences for involvement in the person's treatment; and

(3) provide information about the range of current EIDBI treatment modalities recognized by the commissioner.

Subd. 5a. **Comprehensive multidisciplinary evaluation provider qualification.** A CMDE provider must:

(1) be a licensed physician, an advanced practice registered nurse, a physician assistant, a mental health professional, or a clinical trainee who is qualified according to section 245I.04, subdivision 6;

(2) have at least 2,000 hours of clinical experience in the evaluation and treatment of people with ASD or a related condition or equivalent documented coursework at the graduate level by an accredited university in the following content areas: ASD or a related condition diagnosis, ASD or a related condition treatment strategies, and child development; and

(3) be able to diagnose, evaluate, or provide treatment within the provider's scope of practice and professional license.

Subd. 6. **Individual treatment plan.** (a) The QSP, level I treatment provider, or level II treatment provider who integrates and coordinates person and family information from the CMDE and ITP progress monitoring process to develop the ITP must develop and monitor the ITP.

(b) Each person's ITP must be:

(1) culturally and linguistically appropriate, as required under subdivision 3a, individualized, and person-centered; and

(2) based on the diagnosis and CMDE information specified in subdivisions 4 and 5.

(c) The ITP must specify:

(1) the medically necessary treatment and service;

(2) the treatment modality that shall be used to meet the goals and objectives, including:

(i) baseline measures and projected dates of accomplishment;

(ii) the frequency, intensity, location, and duration of each service provided;

(iii) the level of legal representative or primary caregiver training and counseling;

(iv) any change or modification to the physical and social environments necessary to provide a service;

(v) significant changes in the person's condition or family circumstance;

(vi) techniques that support and are consistent with the person's communication mode and learning style;

(vii) the name of the QSP; and

(viii) progress monitoring results and goal mastery data; and

(3) the discharge criteria that must be used and a defined transition plan that meets the requirement of paragraph (g).

(d) Implementation of the ITP must be supervised by a QSP.

(e) The ITP must be submitted to the commissioner and the person or the person's legal representative for approval in a manner determined by the commissioner for this purpose.

(f) A service included in the ITP must meet all applicable requirements for medical necessity and coverage.

(g) To terminate service, the provider must send notice of termination to the person or the person's legal representative. The transition period begins when the person or the person's legal representative receives notice of termination from the EIDBI service and ends when the EIDBI service is terminated. Up to 30 days of continued service is allowed during the transition period. Services during the transition period shall be consistent with the ITP. The transition plan must include:

(1) protocols for changing service when medically necessary;

(2) how the transition will occur;

(3) the time allowed to make the transition; and

(4) a description of how the person or the person's legal representative will be informed of and involved in the transition.

Subd. 7. **Individual treatment plan progress monitoring.** (a) An ITP progress monitoring must be submitted after each six months of treatment, or more frequently as determined by the CMDE provider or QSP, to determine if progress is being made toward targeted functional and generalizable goals specified in the ITP. Based on the results of ITP progress monitoring, the ITP must be adjusted as needed and must document that the EIDBI service continues to be medically necessary for the person or the person is referred to other services.

(b) The ITP progress monitoring must include:

(1) input from the person's legal representative or the person's primary caregiver;

(2) an observation of the person that is performed by the QSP, level I treatment provider, or level II treatment provider and may include input from licensed special education staff or other licensed health care provider;

(3) documentation of the person's current level of performance on primary treatment goal domains including when a goal or objective is achieved, changed, or discontinued;

(4) any significant change in the person's condition or family circumstances;

(5) any treatment plan modification and the rationale for any change made, including treatment modality, intensity, frequency, and duration; and

(6) recommendations for continued treatment.

(c) The ITP progress monitoring must be submitted to the commissioner and the person or the person's legal representative in a manner determined by the commissioner for the reauthorization of EIDBI services.

(d) A person who continues to make reasonable progress toward treatment goals as specified in the ITP is eligible to continue receiving EIDBI services.

(e) A person's treatment shall continue during the ITP progress monitoring using the process determined under this subdivision. Treatment may continue during an appeal pursuant to section 256.045.

Subd. 8. **Refining the benefit with stakeholders.** Before making revisions to the EIDBI benefit or proposing statutory changes to this section, the commissioner must consult with stakeholders and consider recommendations from the Department of Human Services Early Intensive Developmental and Behavioral Intervention Advisory Council, the early intensive developmental and behavioral intervention learning collaborative, and the Departments of Health, Education, Employment and Economic Development, and Human Services. Revisions and proposed statutory changes subject to this subdivision 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 professionals certified in other treatment approaches recognized by the department or trained in ASD or a related condition and child development should be added as professionals qualified to provide EIDBI clinical supervision or other functions under medical assistance;

(2) refinement of uniform parameters for CMDE and ongoing ITP progress monitoring standards;

(3) the design of an effective and consistent process for assessing the person's and the person's legal representative's and the person's caregiver's preferences and options to participate in the person's early intervention treatment and efficacy of methods to involve and educate the person's legal representative and caregiver in the treatment of the person;

(4) formulation of a collaborative process in which professionals have opportunities to collectively inform provider standards and qualifications; standards for CMDE; medical necessity determination; efficacy of treatment apparatus, including modality, intensity, frequency, and duration; and ITP progress monitoring processes to support quality improvement of EIDBI services;

(5) coordination of this benefit and its interaction with other services provided by the Departments of Human Services, Health, Employment and Economic Development, and Education;

(6) evaluation, on an ongoing basis, of EIDBI services outcomes and efficacy of treatment modalities provided to people under this benefit; and

(7) as provided under subdivision 17, determination of the availability of qualified EIDBI providers with necessary expertise and training in ASD or a related condition throughout the state to assess whether there are sufficient professionals to provide timely access and prevent delay in the CMDE and treatment of a person with ASD or a related condition.

Subd. 9. MS 2024 [Repealed, 1Sp2025 c 9 art 6 s 19]

Subd. 10. **Coordination between agencies and other benefits.** (a) 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.

(b) An EIDBI service provided under this section is not intended to replace a service provided in school or other settings. A person's ITP must document that EIDBI services coordinate with, but do not include or replace, special education and related services defined in the person's individualized education plan (IEP), or individualized family service plan (IFSP), when the service is available under the Individuals with Disabilities Education Improvement Act of 2004, United States Code, title 20, chapter 33, through a local

education agency. This provision does not preclude EIDBI treatment during school hours. A program for birth to three years of age and additional resources must also coordinate with EIDBI services. A resource for a person over 18 years of age must also be coordinated with EIDBI services under this section.

(c) The commissioner shall integrate medical authorization procedures for an EIDBI service with authorization procedures for other health and mental health services and home and community-based services to ensure that the person receives services that are the most appropriate and effective in meeting the person's needs.

Subd. 11. **Federal approval of the EIDBI 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 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 20 years of age.

Subd. 12. **EIDBI benefit; training provided.** After approval of the EIDBI 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 EIDBI 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 EIDBI benefit and how to access it.

Subd. 13. **Covered services.** (a) The services described in paragraphs (b) to (l) are eligible for reimbursement by medical assistance under this section. Services must be provided by a qualified EIDBI provider and supervised by a QSP. An EIDBI service must address the person's medically necessary treatment goals and must be targeted to develop, enhance, or maintain the individual developmental skills of a person with ASD or a related condition to improve functional communication, including nonverbal or social communication, social or interpersonal interaction, restrictive or repetitive behaviors, hyperreactivity or hyporeactivity to sensory input, behavioral challenges and self-regulation, cognition, learning and play, self-care, and safety.

(b) EIDBI treatment must be delivered consistent with the standards of an approved modality, as published by the commissioner. EIDBI modalities include:

(1) applied behavior analysis (ABA);

(2) developmental individual-difference relationship-based model (DIR/Floortime);

(3) early start Denver model (ESDM); or

(4) relationship development intervention (RDI).

(c) An EIDBI provider may use one or more of the EIDBI modalities in paragraph (b), clauses (1) to (4), as the primary modality for treatment as a covered service, or several EIDBI modalities in combination as the primary modality of treatment, as approved by the commissioner. An EIDBI provider that identifies

and provides assurance of qualifications for a single specific treatment modality, including an EIDBI provider with advanced certification overseeing implementation, must document the required qualifications to meet fidelity to the specific model in a manner determined by the commissioner.

(d) Each qualified EIDBI provider must identify and provide assurance of qualifications for professional licensure certification, or training in evidence-based treatment methods, and must document the required qualifications outlined in subdivision 15 in a manner determined by the commissioner.

(e) CMDE is a comprehensive evaluation of the person's developmental status to determine medical necessity for EIDBI services and meets the requirements of subdivision 5. The services must be provided by a qualified CMDE provider.

(f) EIDBI intervention observation and direction is the clinical direction and oversight of EIDBI services by the QSP, level I treatment provider, or level II treatment provider, including developmental and behavioral techniques, progress measurement, data collection, function of behaviors, and generalization of acquired skills for the direct benefit of a person. EIDBI intervention observation and direction informs any modification of the current treatment protocol to support the outcomes outlined in the ITP.

(g) Intervention is medically necessary direct treatment provided to a person with ASD or a related condition as outlined in their ITP. All intervention services must be provided under the direction of a QSP. Intervention may take place across multiple settings. The frequency and intensity of intervention services are provided based on the number of treatment goals, person and family or caregiver preferences, and other factors. Intervention services may be provided individually or in a group. Intervention with a higher provider ratio may occur when deemed medically necessary through the person's ITP.

(1) Individual intervention is treatment by protocol administered by a single qualified EIDBI provider delivered to one person.

(2) Group intervention is treatment by protocol provided by one or more qualified EIDBI providers, delivered to at least two people who receive EIDBI services.

(3) Higher provider ratio intervention is treatment with protocol modification provided by two or more qualified EIDBI providers delivered to one person in an environment that meets the person's needs and under the direction of the QSP or level I provider.

(h) ITP development and ITP progress monitoring is development of the initial, annual, and progress monitoring of an ITP. ITP development and ITP progress monitoring documents provide oversight and ongoing evaluation of a person's treatment and progress on targeted goals and objectives and integrate and coordinate the person's and the person's legal representative's information from the CMDE and ITP progress monitoring. This service must be reviewed and completed by the QSP, and may include input from a level I provider or a level II provider.

(i) Family caregiver training and counseling is specialized training and education for a family or primary caregiver to understand the person's developmental status and help with the person's needs and development. This service must be provided by the QSP, level I provider, or level II provider.

(j) A coordinated care conference is a voluntary meeting with the person and the person's family to review the CMDE or ITP progress monitoring and to integrate and coordinate services across providers and service-delivery systems to develop the ITP. This service may include the CMDE provider, QSP, a level I provider, or a level II provider.

(k) Travel time is allowable billing for traveling to and from the person's home, school, a community setting, or place of service outside of an EIDBI center, clinic, or office from a specified location to provide in-person EIDBI intervention, observation and direction, or family caregiver training and counseling. The person's ITP must specify the reasons the provider must travel to the person.

(l) Medical assistance covers medically necessary EIDBI services and consultations delivered via telehealth, as defined under section 256B.0625, subdivision 3b, in the same manner as if the service or consultation was delivered in person.

Subd. 14. **Person's rights.** A person or the person's legal representative has the right to:

(1) protection as defined under the health care bill of rights under section 144.651;

(2) designate an advocate to be present in all aspects of the person's and person's family's services at the request of the person or the person's legal representative;

(3) be informed of the agency policy on assigning staff to a person;

(4) be informed of the opportunity to observe the person while receiving services;

(5) be informed of services in a manner that respects and takes into consideration the person's and the person's legal representative's culture, values, and preferences in accordance with subdivision 3a;

(6) be free from seclusion and restraint, except for emergency use of manual restraint in emergencies as defined in section 245D.02, subdivision 8a;

(7) be under the supervision of a responsible adult at all times;

(8) be notified by the agency within 24 hours if an incident occurs or the person is injured while receiving services, including what occurred and how agency staff responded to the incident;

(9) request a voluntary coordinated care conference;

(10) request a CMDE provider of the person's or the person's legal representative's choice; and

(11) be free of all prohibitions as defined in Minnesota Rules, part 9544.0060.

Subd. 15. **EIDBI provider qualifications.** (a) A QSP must be an employee of an agency and be:

(1) either a licensed mental health professional or a licensed behavior analyst, and have at least 2,000 hours of supervised clinical experience or training in examining or treating people with ASD or a related condition or equivalent documented coursework at the graduate level by an accredited university in ASD diagnostics, ASD developmental and behavioral treatment strategies, and typical child development; or

(2) a developmental or behavioral pediatrician who has at least 2,000 hours of supervised clinical experience or training in examining or treating people with ASD or a related condition or equivalent documented coursework at the graduate level by an accredited university in the areas of ASD diagnostics, ASD developmental and behavioral treatment strategies, and typical child development.

(b) A level I treatment provider must be an employee of an agency and:

(1) have at least 2,000 hours of supervised clinical experience or training in examining or treating people with ASD or a related condition or equivalent documented coursework at the graduate level by an accredited university in ASD diagnostics, ASD developmental and behavioral treatment strategies, and typical child development or an equivalent combination of documented coursework or hours of experience; and

(2) meet one of the following requirements:

(i) have a master's degree in behavioral health or child development or related fields including, but not limited to, mental health, special education, social work, psychology, speech pathology, or occupational therapy from an accredited college or university;

(ii) have a bachelor's degree in a behavioral health, child development, or related field including, but not limited to, mental health, special education, social work, psychology, speech pathology, or occupational therapy, from an accredited college or university, and advanced certification in a treatment modality recognized by the department;

(iii) be a board-certified behavior analyst as defined by the Behavior Analyst Certification Board or a qualified behavior analyst as defined by the Qualified Applied Behavior Analysis Credentialing Board;

(iv) be a board-certified assistant behavior analyst with 4,000 hours of supervised clinical experience that meets all registration, supervision, and continuing education requirements of the certification;

(v) have a bachelor's degree from an accredited college or university in behavioral health, child development, or a related field; have at least 6,000 hours of clinical experience providing early intervention services in the modality the EIDBI agency uses; and have completed the EIDBI level III provider training requirements; or

(vi) be currently enrolled or have completed a master's degree program at an accredited college or university in behavioral health, child development, or a related field and receive intervention observation and direction from a qualified supervising professional at least monthly until having completed 2,000 hours of supervised clinical experience.

(c) A level II treatment provider must be an employee of an agency and must be:

(1) a person who has a bachelor's degree from an accredited college or university in a behavioral or child development science or related field including, but not limited to, mental health, special education, social work, psychology, speech pathology, or occupational therapy; and meets at least one of the following:

(i) has at least 1,000 hours of supervised clinical experience or training in examining or treating people with ASD or a related condition or equivalent documented coursework at the graduate level by an accredited university in ASD diagnostics, ASD developmental and behavioral treatment strategies, and typical child development or a combination of coursework or hours of experience;

(ii) has certification as a board-certified assistant behavior analyst from the Behavior Analyst Certification Board or a qualified autism service practitioner from the Qualified Applied Behavior Analysis Credentialing Board;

(iii) is a registered behavior technician as defined by the Behavior Analyst Certification Board or an applied behavior analysis technician as defined by the Qualified Applied Behavior Analysis Credentialing Board; or

(iv) is certified in one of the other treatment modalities recognized by the department;

(2) a person who has:

(i) an associate's degree in a behavioral or child development science or related field including, but not limited to, mental health, special education, social work, psychology, speech pathology, or occupational therapy from an accredited college or university; and

(ii) at least 2,000 hours of supervised clinical experience in delivering treatment to people with ASD or a related condition. Hours worked as a mental health behavioral aide or level III treatment provider may be included in the required hours of experience;

(3) a person who has at least 4,000 hours of supervised clinical experience in delivering treatment to people with ASD or a related condition. Hours worked as a mental health behavioral aide or level III treatment provider may be included in the required hours of experience;

(4) a person who is a graduate student in a behavioral science, child development science, or related field and is receiving clinical supervision by a QSP affiliated with an agency to meet the clinical training requirements for experience and training with people with ASD or a related condition;

(5) a person who is at least 18 years of age and who:

(i) is fluent in a non-English language or is an individual certified by a Tribal Nation;

(ii) completed the level III EIDBI training requirements; and

(iii) receives observation and direction from a QSP or level I treatment provider at least once a week until the person meets 1,000 hours of supervised clinical experience;

(6) a person currently enrolled in a bachelor's degree program at an accredited college or university in behavioral health, child development, or a related field who receives intervention observation and direction from a QSP or level I provider at least twice monthly until having completed 1,000 hours of supervised clinical experience; or

(7) a person who is at least 18 years of age, holds a current certification in the treatment modality of the EIDBI agency, receives intervention observation and direction from a provider with an advance certification at least weekly until having completed 1,000 hours of supervised clinical experience, and has completed the level III EIDBI training requirements.

(d) A level III treatment provider must be an employee of an agency, have completed the level III training requirement, be at least 18 years of age, and have at least one of the following:

(1) a high school diploma or commissioner of education-selected high school equivalency certification;

(2) fluency in a non-English language or Tribal Nation certification;

(3) one year of experience as a primary personal care assistant, community health worker, waiver service provider, or special education assistant to a person with ASD or a related condition within the previous five years; or

(4) completion of all required EIDBI training within six months of employment.

Subd. 16. **Agency duties.** (a) An agency delivering an EIDBI service under this section must:

(1) enroll as a medical assistance Minnesota health care program provider according to Minnesota Rules, part 9505.0195, and sections 256B.044 to 256B.0448 and meet all applicable provider standards and requirements;

(2) designate an individual as the agency's compliance officer who must perform the duties described in section 256B.044, subdivision 8, paragraph (b);

(3) demonstrate compliance with federal and state laws for the delivery of and billing for EIDBI service;

(4) verify and maintain records of a service provided to the person or the person's legal representative as required under Minnesota Rules, parts 9505.2175 and 9505.2197;

(5) demonstrate that while enrolled or seeking enrollment as a Minnesota health care program provider the agency did not have a lead agency contract or provider agreement discontinued because of a conviction of fraud; or did not have an owner, board member, or manager fail a state or federal criminal background check or appear on the list of excluded individuals or entities maintained by the federal Department of Human Services Office of Inspector General;

(6) have established business practices including written policies and procedures, internal controls, and a system that demonstrates the organization's ability to deliver quality EIDBI services, appropriately submit claims, conduct required staff training, document staff qualifications, document service activities, and document service quality;

(7) have an office located in Minnesota or a border state;

(8) initiate a background study as required under subdivision 16a;

(9) report maltreatment according to section 626.557 and chapter 260E;

(10) comply with any data requests consistent with the Minnesota Government Data Practices Act, sections 256B.064 and 256B.27;

(11) provide training for all agency staff on the requirements and responsibilities listed in the Maltreatment of Minors Act, chapter 260E, and the Vulnerable Adult Protection Act, section 626.557, including mandated and voluntary reporting, nonretaliation, and the agency's policy for all staff on how to report suspected abuse and neglect;

(12) have a written policy to resolve issues collaboratively with the person and the person's legal representative when possible. The policy must include a timeline for when the person and the person's legal representative will be notified about issues that arise in the provision of services;

(13) provide the person's legal representative with prompt notification if the person is injured while being served by the agency. An incident report must be completed by the agency staff member in charge of the person. A copy of all incident and injury reports must remain on file at the agency for at least five years from the report of the incident;

(14) before starting a service, provide the person or the person's legal representative a description of the treatment modality that the person shall receive, including the staffing certification levels and training of the staff who shall provide a treatment;

(15) provide clinical supervision for a minimum of one hour for every 16 hours of direct treatment per person, unless otherwise authorized in the person's individual treatment plan; and

(16) provide the required EIDBI intervention observation and direction by a QSP at least once per month. Notwithstanding subdivision 13, paragraph (l), required EIDBI intervention observation and direction under this clause may be conducted via telehealth provided that no more than two consecutive monthly required EIDBI intervention observation and direction sessions under this clause are conducted via telehealth.

(b) Upon request of the commissioner, an agency delivering services under this section must:

(1) identify the agency's controlling individuals, as defined under section 245A.02, subdivision 5a;

(2) provide disclosures of the use of billing agencies and other consultants who do not provide EIDBI services; and

(3) provide copies of any contracts with consultants or independent contractors who do not provide EIDBI services, including hours contracted and responsibilities.

(c) When delivering the ITP, and annually thereafter, an agency must provide the person or the person's legal representative with:

(1) a written copy and a verbal explanation of the person's or person's legal representative's rights and the agency's responsibilities;

(2) documentation in the person's file the date that the person or the person's legal representative received a copy and explanation of the person's or person's legal representative's rights and the agency's responsibilities; and

(3) reasonable accommodations to provide the information in another format or language as needed to facilitate understanding of the person's or person's legal representative's rights and the agency's responsibilities.

Subd. 16a. **Background studies.** (a) An early intensive developmental and behavioral intervention services agency must fulfill any background studies requirements under this section by initiating a background study through the commissioner's NETStudy 2.0 system as provided under chapter 245C and must maintain documentation of background study requests and results.

(b) Before an individual subject to the background study requirements under this subdivision has direct contact with a person served by the provider, the agency must have received a notice from the commissioner that the subject of the background study is:

(1) not disqualified under section 245C.14; or

(2) disqualified but the subject of the study has received a set-aside of the disqualification under section 245C.22.

Subd. 17. **Provider shortage; authority for exceptions.** (a) In consultation with the Early Intensive Developmental and Behavioral Intervention Advisory Council and stakeholders, including agencies, professionals, parents of people with ASD or a related condition, and advocacy organizations, the commissioner shall determine if a shortage of EIDBI providers exists. For the purposes of this subdivision, "shortage of EIDBI providers" means a lack of availability of providers who meet the EIDBI provider qualification requirements under subdivision 15 that results in the delay of access to timely services under this section, or that significantly impairs the ability of a provider agency to have sufficient providers to meet the requirements of this section. The commissioner shall consider geographic factors when determining the prevalence of a shortage. The commissioner may determine that a shortage exists only in a specific region of the state, multiple regions of the state, or statewide. The commissioner shall also consider the availability of various types of treatment modalities covered under this section.

(b) The commissioner, in consultation with the Early Intensive Developmental and Behavioral Intervention Advisory Council and stakeholders, must establish processes and criteria for granting an exception under this paragraph. The commissioner may grant an exception only if the exception would not compromise a person's safety and not diminish the effectiveness of the treatment. The commissioner may establish an expiration date for an exception granted under this paragraph. The commissioner may grant an exception for the following:

(1) EIDBI provider qualifications under this section;

(2) medical assistance provider enrollment requirements under sections 256B.044 to 256B.0448; or

(3) EIDBI provider or agency standards or requirements.

(c) If the commissioner, in consultation with the Early Intensive Developmental and Behavioral Intervention Advisory Council and stakeholders, determines that a shortage no longer exists, the commissioner must submit a notice that a shortage no longer exists to the chairs and ranking minority members of the senate and the house of representatives committees with jurisdiction over health and human services. The commissioner must post the notice for public comment for 30 days. The commissioner shall consider public comments before submitting to the legislature a request to end the shortage declaration. The commissioner shall not declare the shortage of EIDBI providers ended without direction from the legislature to declare it ended.

Subd. 18. **Site visits and sanctions.** (a) The commissioner may conduct unannounced on-site inspections of any and all EIDBI agencies and service locations to verify that information submitted to the commissioner is accurate, determine compliance with all enrollment requirements, investigate reports of maltreatment, determine compliance with service delivery and billing requirements, and determine compliance with any other applicable laws or rules.

(b) The commissioner may withhold payment from an agency or suspend or terminate the agency's enrollment number if the agency fails to provide access to the agency's service locations or records or fails to comply with documentation requirements under subdivision 19 or the commissioner determines the agency has failed to comply fully with applicable laws or rules. The provider has the right to appeal the decision of the commissioner under section 256B.064.

Subd. 19. **Documentation requirements.** (a) CMDE and EIDBI providers must ensure that all documentation, including but not limited to health service records and personnel files, complies with this subdivision, subdivision 16, and Minnesota Rules, parts 9505.2175 and 9505.2197. Documentation must be complete, legible, accurate, and readily accessible.

(b) All documentation must:

(1) be legible and understandable to individuals outside service delivery;

(2) include the participant's name on each health record page and the provider's name on each personnel file page;

(3) be signed and dated by the provider completing the documentation with the provider's full name, title, and credentials;

(4) be entered within 72 hours of service and contain a record and explanation of any delays in entry;

(5) clearly reflect clinical decision-making and support medical necessity;

(6) be securely stored in accordance with the Health Insurance Portability and Accountability Act (HIPAA), Public Law 104-191;

(7) be stored in accordance with state and federal document retention laws;

(8) be available for review or audit;

(9) include a record of caregiver involvement where applicable; and

(10) include a record of supervision and oversight for staff providing services requiring supervision under EIDBI policy.

(c) Each EIDBI service occurrence must be documented in a progress note in a manner and with the information determined by the commissioner.

(d) All providers must maintain current personnel records for each employee in a manner determined by the commissioner that include:

(1) the employee's name, contact information, and hire date;

(2) the employee's completed employment application and acknowledgment of duties;

(3) the job description for the employee's job with the effective date;

(4) verification of the employee's qualifications, including but not limited to education, licenses, certifications, enrollment attestation, degrees, transcripts, and experience;

(5) a background study pursuant to chapter 245C with a notice from the commissioner that the subject of the study is:

(i) not disqualified under section 245C.14; or

(ii) disqualified but the subject of the study has received a set-aside of the disqualification under section 245C.22;

(6) orientation and required training the employee attended, including but not limited to training on mandated reporting, cultural responsiveness, and EIDBI competencies;

(7) the dates of the employee's first supervised and unsupervised client contact following employment;

(8) documentation of supervision received by the employee, including but not limited to the supervisor's name and credentials, dates of supervision, supervision content, and the employee's signature indicating the accuracy of the documented supervision;

(9) the employee's CPR and emergency response training, if required; and

(10) the employee's annual performance evaluations.

(e) If an incident occurs or the person is injured while receiving services, the provider must document what occurred and how staff responded to the incident.

Subd. 20. **Billing limits.** (a) Effective July 1, 2027, or upon federal approval, whichever is later, the following billing limits apply to early intensive developmental and behavioral intervention services:

(1) intensive services: 40 hours per week per recipient;

(2) travel: two hours per day per recipient;

(3) observation and direction: 20 hours per week per recipient; and

(4) individual treatment and planning: 300 units per year per recipient.

(b) The commissioner must grant exceptions to the billing limits under paragraph (a) when services in excess of the billing limits are determined to be medically necessary. A provider must apply to the

commissioner for an exception on the forms and in the manner prescribed by the commissioner. A determination under this paragraph is final and not subject to appeal.

History: *2013 c 108 art 7 s 14; 2014 c 275 art 1 s 63,140; 2014 c 312 art 27 s 52-55; 2017 c 19 s 1; 1Sp2017 c 5 art 10 s 7; 2018 c 182 art 1 s 51; 1Sp2020 c 2 art 5 s 41-48; art 8 s 93; 2021 c 30 art 17 s 104-106; 1Sp2021 c 7 art 2 s 69; art 6 s 23; 2022 c 58 s 152-154; 2022 c 98 art 4 s 40-42; art 14 s 22; 2023 c 61 art 1 s 19; 2024 c 125 art 1 s 19; 2024 c 127 art 46 s 19; 1Sp2025 c 9 art 6 s 7-13; 2026 c 95 art 4 s 23-26; 2026 c 121 art 3 s 57,58; art 9 s 20*

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 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.

(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 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; and 626.557; and chapters 245C and 260E, 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. MS 2000 [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; 1Sp2020 c 2 art 8 s 94*

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. 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*

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 260E.06, subdivision 1, and 626.5572, subdivision 16.

History: *1997 c 203 art 7 s 22; 1Sp2020 c 2 art 8 s 95*

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*

256B.096 Subdivision 1. MS 2012 [Repealed, 2013 c 108 art 7 s 64]

Subd. 2. MS 2012 [Repealed, 2013 c 108 art 7 s 64]

Subd. 3. MS 2012 [Repealed, 2013 c 108 art 7 s 64]

Subd. 4. MS 2012 [Repealed, 2013 c 108 art 7 s 64]

Subd. 5. MS 2012 [Expired, 2012 c 216 art 9 s 25]

256B.097 REGIONAL AND SYSTEMS IMPROVEMENT FOR MINNESOTANS WHO HAVE DISABILITIES.

Subdivision 1. MS 2020 [Repealed, 1Sp2021 c 7 art 13 s 79]

Subd. 2. MS 2020 [Repealed, 1Sp2021 c 7 art 13 s 79]

Subd. 3. MS 2020 [Repealed, 1Sp2021 c 7 art 13 s 79]

Subd. 4. MS 2020 [Repealed, 1Sp2021 c 7 art 13 s 79]

Subd. 5. MS 2020 [Repealed, 1Sp2021 c 7 art 13 s 79]

Subd. 6. MS 2020 [Repealed, 1Sp2021 c 7 art 13 s 79]

Subd. 7. **Regional quality councils and systems improvement.** The commissioner of human services shall maintain the regional quality councils initially established under Minnesota Statutes 2020, section 256B.097, subdivision 4. The regional quality councils shall:

(1) support efforts and initiatives that drive overall systems and social change to promote inclusion of people who have disabilities in the state of Minnesota;

(2) improve person-centered outcomes in disability services; and

(3) identify or enhance quality of life indicators for people who have disabilities.

Subd. 8. **Membership and staff.** (a) Regional quality councils shall be comprised of key stakeholders including, but not limited to:

(1) individuals who have disabilities;

(2) family members of people who have disabilities;

(3) disability service providers;

(4) disability advocacy groups;

(5) lead agency staff; and

(6) staff of state agencies with jurisdiction over special education and disability services.

(b) Membership in a regional quality council must be representative of the communities in which the council operates, with an emphasis on individuals with lived experience from diverse racial and cultural backgrounds.

(c) Each regional quality council may hire staff to perform the duties assigned in subdivision 9.

Subd. 9. **Duties.** (a) Each regional quality council shall:

(1) identify issues and barriers that impede Minnesotans who have disabilities from optimizing choice of home and community-based services;

(2) promote informed decision-making, autonomy, and self-direction;

(3) analyze and review quality outcomes and critical incident data, and immediately report incidents of life safety concerns to the Department of Human Services Licensing Division;

(4) inform a comprehensive system for effective incident reporting, investigation, analysis, and follow-up;

(5) collaborate on projects and initiatives to advance priorities shared with state agencies, lead agencies, educational institutions, advocacy organizations, community partners, and other entities engaged in disability service improvements;

(6) establish partnerships and working relationships with individuals and groups in the regions;

(7) identify and implement regional and statewide quality improvement projects;

(8) transform systems and drive social change in alignment with the disability rights and disability justice movements identified by leaders who have disabilities;

(9) provide information and training programs for persons who have disabilities and their families and legal representatives on formal and informal support options and quality expectations;

(10) make recommendations to state agencies and other key decision-makers regarding disability services and supports;

(11) submit every two years a report to legislative committees with jurisdiction over disability services on the status, outcomes, improvement priorities, and activities in the region;

(12) support people by advocating to resolve complaints between the counties, providers, persons receiving services, and their families and legal representatives; and

(13) recruit, train, and assign duties to regional quality council teams, including council members, interns, and volunteers, taking into account the skills necessary for the team members to be successful in this work.

(b) Each regional quality council may engage in quality improvement initiatives related to, but not limited to:

(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 persons 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 persons with developmental disabilities.

(c) Each regional quality council's work must be informed and directed by the needs and desires of persons who have disabilities in the region in which the council operates.

Subd. 10. **Compensation.** (a) A member of a regional quality council who does not receive a salary or wages from an employer may be paid a per diem and reimbursed for expenses related to the member's participation in efforts and initiatives described in subdivision 9 in the same manner and in an amount not to exceed the amount authorized by the commissioner's plan adopted under section 43A.18, subdivision 2.

(b) Regional quality councils may charge fees for their services.

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; 1Sp2020 c 2 art 8 s 96,97; 1Sp2021 c 7 art 13 s 20-23,78*

256B.10 MS 1974 [Repealed, 1976 c 131 s 2]

256B.11 MS 1974 [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 county agency in all matters pertaining hereto. To prosecute under this chapter or sections 609.467; 609.52, subdivision 2; and 609.542 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; 2025 c 38 art 5 s 30; 2026 c 127 art 7 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*

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 do not apply to parents of children whose eligibility for medical assistance was determined without deeming of the parents' resources and income under the Tax Equity and Fiscal Responsibility Act (TEFRA) option or to parents of children accessing home and community-based waiver services. 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. MS 2012 [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; 2023 c 61 art 3 s 13*

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 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, the general assistance medical care program formerly codified under chapter 256D, and alternative care for nonmedical assistance recipients under section 256B.0913.

(c) For purposes of this section, "medical assistance" does not include Medicare cost-sharing benefits in accordance with United States Code, title 42, section 1396p.

(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 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 amount paid for medical assistance as limited under subdivision 2 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, transfer-on-death of title or deed, 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 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, advanced practice registered nurse, or physician assistant. 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;

(2) the person received general assistance medical care services under the program formerly codified under chapter 256D; or

(3) the person was 55 years of age or older and received medical assistance services that consisted of nursing facility services, home and community-based services, or related hospital and prescription drug benefits.

(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.

Subd. 1b. MS 2000 [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 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 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 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 558A 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;

(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 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 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 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 1k, 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.** (a) The claim shall include only:

(1) the amount of medical assistance rendered to recipients 55 years of age or older that consisted of nursing facility services, home and community-based services, and related hospital and prescription drug services;

(2) the total amount of medical assistance rendered during a period of institutionalization described in subdivision 1a, paragraph (e), clause (1); and

(3) the total amount of general assistance medical care rendered under the program formerly codified under chapter 256D.

The claim shall not include interest. For the purposes of this section, "home and community-based services" has the same meaning it has when used in United States Code, title 42, section 1396p(b)(1)(B)(i), and includes the alternative care program under section 256B.0913, even for periods when alternative care services receive only state funding.

(b) 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 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.

Subd. 2a. MS 2000 [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.

Subd. 3. **Surviving spouse, child, blind child, or child with a disability.** 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 chapter 256S or section 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;

(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; 2016 c 158 art 2 s 94-96; 2016 c 189 art 19 s 14-16; 2017 c 46 s 1-3; 2017 c 59 s 11; 1Sp2017 c 3 art 3 s 108; 2019 c 50 art 1 s 74; 2019 c 54 art 2 s 33; 2026 c 88 art 1 s 128*

256B.16 MS 1969 [Repealed, 1971 c 550 s 2]

256B.17 TRANSFERS OF PROPERTY.

Subdivision 1. MS 1996 [Repealed, 1997 c 107 s 19]

Subd. 2. MS 1996 [Repealed, 1997 c 107 s 19]

Subd. 3. MS 1996 [Repealed, 1997 c 107 s 19]

Subd. 4. MS 1996 [Repealed, 1997 c 107 s 19]

Subd. 5. MS 1996 [Repealed, 1997 c 107 s 19]

Subd. 6. MS 1996 [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. MS 1996 [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 seriously mentally ill 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;

(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. MS 2000 [Repealed, 2002 c 277 s 34]

Subd. 1b. MS 2000 [Repealed, 1Sp2001 c 9 art 2 s 76]

Subd. 1c. MS 2016 [Repealed, 1Sp2017 c 6 art 4 s 67]

Subd. 1d. MS 2008 [Repealed, 2009 c 79 art 8 s 86]

Subd. 1e. **Additional local share of certain nursing facility costs.** Participating local governmental entities that own the physical plant or are the license holders of nursing facilities receiving rate adjustments under section 256R.48, shall be responsible for paying the portion of nonfederal costs calculated under section 256R.48, paragraph (d). 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 256R.48, 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 256R.48, 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 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 MinnesotaCare program enrollees, if the local agency fails to comply with paragraph (a), the local agency is responsible for the entire cost of 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 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. MS 2012 [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; 2016 c 99 art 2 s 4; 2016 c 158 art 2 s 97; 1Sp2025 c 9 art 9 s 6*

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 MS 2009 Supp [Repealed, 2010 c 200 art 1 s 21]

256B.196 INTERGOVERNMENTAL TRANSFERS; HOSPITAL AND PHYSICIAN 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, 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) 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, and ambulance services owned and operated by another governmental entity that chooses to participate by requesting the commissioner to determine an upper payment limit. 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, the city of St. Paul, and other participating governmental entities 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, the city of St. Paul, and other participating governmental entities 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, the city of St. Paul, and other participating governmental entities. A Tribal government that owns and operates an ambulance service is not eligible to participate under this subdivision.

(d) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for physicians, dentists, and other billing professionals affiliated with the University of Minnesota and University of Minnesota Physicians. 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 the University of Minnesota Medical School and University of Minnesota School of Dentistry of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to physicians, dentists, and other billing professionals affiliated with the University of Minnesota and the University of Minnesota Physicians equal to the difference between the established medical assistance payment for physician, dentist, and other billing professional services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to physicians, dentists, and other billing professionals affiliated with the University of Minnesota and the University of Minnesota Physicians.

(e) The commissioner shall inform the transferring governmental entities on an ongoing basis of 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.

(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.

(g) All of the data and funding transactions related to the payments in paragraphs (a) to (d) shall be between the commissioner and the governmental entities.

(h) For purposes of this subdivision, billing professionals are limited to physicians, nurse practitioners, nurse midwives, clinical nurse specialists, physician assistants, anesthesiologists, certified registered nurse anesthetists, dentists, dental hygienists, and dental therapists.

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). All of the intergovernmental transfer payments made by the University of Minnesota Medical School and the University of Minnesota School of Dentistry shall

be used to match federal payments to the University of Minnesota and the University of Minnesota Physicians under subdivision 2, paragraph (e).

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, average commercial rates for physician and other professional services as defined in this section, 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, university schools, 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; 1Sp2017 c 6 art 4 s 45-47; 2021 c 30 art 1 s 16; 2024 c 85 s 71; 2026 c 88 art 1 s 129*

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 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 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; 2024 c 85 s 72*

256B.1973 HENNEPIN HEALTHCARE DIRECTED PAYMENT ARRANGEMENTS.

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

(b) "Billing professionals" means physicians, nurse practitioners, nurse midwives, clinical nurse specialists, physician assistants, anesthesiologists, and certified registered nurse anesthetists, and may include dentists, individually enrolled dental hygienists, and dental therapists.

(c) "Health plan" means a managed care or county-based purchasing plan that is under contract with the commissioner to deliver services to medical assistance enrollees under section 256B.69.

(d) "High medical assistance utilization" means a medical assistance utilization rate equal to the standard established in section 256.969, subdivision 9, paragraph (d), clause (6).

Subd. 2. **Federal approval required.** Each directed payment arrangement under this section is contingent on federal approval and must conform with the requirements for permissible directed managed care organization expenditures under section 256B.6928, subdivision 5.

Subd. 3. **Eligible providers.** Eligible providers under this section are nonstate government teaching hospitals with high medical assistance utilization and a level 1 trauma center and all of the hospital's owned or affiliated billing professionals, ambulance services, sites, and clinics.

Subd. 4. **Voluntary intergovernmental transfers.** A nonstate governmental entity that is eligible to perform intergovernmental transfers may make voluntary intergovernmental transfers to the commissioner. The commissioner shall inform the nonstate governmental entity of the intergovernmental transfers necessary to maximize the allowable directed payments.

Subd. 5. **Commissioner's duties; state-directed fee schedule requirement.** (a) For each federally approved directed payment arrangement under this section that is a state-directed fee schedule requirement, the commissioner shall determine a uniform adjustment factor to be applied to each claim submitted by an eligible provider to a health plan. The uniform adjustment factor shall be determined using the average commercial payer rate or using another method acceptable to the Centers for Medicare and Medicaid Services if the average commercial payer rate is not approved, minus the amount necessary for the plan to satisfy tax liabilities under sections 256.9657 and 297I.05 attributable to the directed payment arrangement. The

commissioner shall ensure that the application of the uniform adjustment factor maximizes the allowable directed payments and does not result in payments exceeding federal limits, and may use an annual settle-up process. The directed payment may be specific to each health plan and prospectively incorporated into capitation payments for that plan.

(b) For each federally approved directed payment arrangement that is a state-directed fee schedule requirement, the commissioner shall develop a plan for the initial implementation of the state-directed fee schedule requirement to ensure that the eligible provider receives the entire permissible value of the federally approved directed payment arrangement. If federal approval of a directed payment arrangement under this subdivision is retroactive, the commissioner shall make a onetime pro rata increase to the uniform adjustment factor and the initial payments in order to include claims submitted between the retroactive federal approval date and the period captured by the initial payments.

Subd. 6. **Health plan duties; submission of claims.** In accordance with its contract, each health plan shall submit to the commissioner payment information for each claim paid to an eligible provider for services provided to a medical assistance enrollee.

Subd. 7. **Health plan duties; directed payments.** In accordance with its contract, each health plan shall make directed payments to the eligible provider in an amount equal to the payment amounts the plan received from the commissioner.

Subd. 8. **State quality goals.** The directed payment arrangement and state-directed fee schedule requirement must align the state quality goals to Hennepin Healthcare medical assistance patients, including unstably housed individuals, those with higher levels of social and clinical risk, limited English proficiency (LEP) patients, adults with serious chronic conditions, and individuals of color. The directed payment arrangement must maintain quality and access to a full range of health care delivery mechanisms for these patients that may include behavioral health, emergent care, preventive care, hospitalization, transportation, interpreter services, and pharmaceutical services. The commissioner, in consultation with Hennepin Healthcare, shall submit to the Centers for Medicare and Medicaid Services a methodology to measure access to care and the achievement of state quality goals.

Subd. 9. **Interaction with other directed payments.** (a) An eligible provider under subdivision 3 may participate in the hospital directed payment program under section 256B.1974 for inpatient hospital services, outpatient hospital services, or both. A provider participating in the hospital directed payment program must not receive a directed payment under this section for any provider classes paid via the hospital directed payment program. A hospital subject to this section must notify the commissioner in writing no later than 30 days after enactment of this subdivision of the hospital's intention to participate in the hospital directed payment program under section 256B.1974 for inpatient hospital services, outpatient hospital services, or both.

(b) The election under this subdivision is a onetime election, except that if an eligible provider elects to participate in the hospital directed payment program, and the hospital directed payment program expires or is not federally approved, the eligible provider may subsequently elect to participate in the directed payment under this section.

(c) If an eligible provider elects not to participate in the hospital directed payment program under section 256B.1974 and the federal statutes or regulations related to hospital directed payment programs are subsequently substantially changed, the eligible provider may elect to participate in the hospital directed payment program under section 256B.1974.

(d) The effective date of the election to participate in the hospital directed payment program under this section must align with the beginning of the calendar year in which payment rates under this section are updated. The eligible provider must notify the commissioner of the eligible provider's intention to make the election ten months before the effective date of the election.

[See Note.]

History: *2021 c 30 art 1 s 17; 1Sp2025 c 3 art 8 s 20,21; 2026 c 88 art 1 s 130; 2026 c 127 art 5 s 9*

NOTE: Subdivision 9, as added by Laws 2025, First Special Session chapter 3, article 8, section 21, is effective upon federal approval of the following: (1) the waiver for the assessment required under Minnesota Statutes, section 256.9657, subdivision 2b; and (2) the hospital directed payment program under Minnesota Statutes, section 256B.1974. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2025, First Special Session chapter 3, article 8, section 21, the effective date.

256B.1974 HOSPITAL DIRECTED PAYMENT PROGRAM.

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

(b) "Eligible hospital" has the meaning given in section 256.9657, subdivision 2b, paragraph (a), clause (1).

(c) "Health plan" means a managed care plan or county-based purchasing plan that is under contract with the commissioner to deliver services to medical assistance enrollees under section 256B.69 or 256B.692.

Subd. 2. **Required conditions for program.** The hospital directed payment program must conform with the requirements for permissible directed managed care organization expenditures under section 256B.6928, subdivision 5.

Subd. 3. **Commissioner's duties; state-directed fee schedule requirement.** (a) For each federally approved directed payment program that is a state-directed fee schedule requirement that includes a quarterly payment amount to be submitted by each health plan to each eligible hospital, the commissioner must determine the quarterly payment amount using the statewide average commercial payer rate, or using another method acceptable to the Centers for Medicare and Medicaid Services if the statewide average commercial payer rate is not approved. The commissioner must ensure that the application of the quarterly payment amounts maximizes the amount generated by the hospital assessment in section 256.9657, subdivision 2b, for allowable directed payments and does not result in payments exceeding federal limits.

(b) The commissioner must use an annual settle-up process to determine the accuracy of the amounts paid by the commissioner to health plans for directed payments to hospitals under this section. The commissioner's settle-up determination must occur within one year of the payment of the applicable amounts to health plans. If the commissioner determines the amount paid to a health plan exceeds or is less than the amount required under this section, the commissioner must pay an additional amount to the health plan for directed payments to hospitals or require a refund from the health plan for an overpayment. Any additional amount required to be paid by the commissioner to a health plan, or any refund to the commissioner from a health plan, must be paid by the immediately following April 1. Additional amounts received by a health plan under this paragraph must be paid to the eligible hospital in accordance with this section. Any refund amount the commissioner determines is owed by a health plan under this paragraph must be paid back by the eligible hospital in accordance with this section.

(c) On and after January 1, 2028, if the federal regulations set forth in Code of Federal Regulations, title 42, parts 430, 438, and 457, and applicable to this section remain effective, the hospital directed payment program may be specific to each health plan and prospectively incorporated into capitation payments for that plan.

(d) For each federally approved directed payment program under this section that is a state-directed fee schedule requirement, the commissioner must develop a plan for the initial implementation of the state-directed fee schedule requirement to ensure that eligible hospitals receive the entire permissible value of the federally approved directed payment.

(e) Directed payments under this section must only be used to supplement, and not supplant, medical assistance reimbursement to eligible hospitals. The directed payment program must not modify, reduce, or offset the medical assistance payment rates determined for each eligible hospital as required by section 256.969.

(f) The commissioner must require health plans to make quarterly directed payments according to this section.

(g) Health plans must make quarterly directed payments using electronic funds transfers, if the eligible hospital provides the information necessary to process such transfers, and in accordance with directions provided by the commissioner. Health plans must make quarterly directed payments:

(1) for the first two quarters for which such payments are due, within 30 calendar days of the date the commissioner issued sufficient payments to the health plan to make the directed payments according to this section; and

(2) for all subsequent quarters, within ten calendar days of the date the commissioner issued sufficient payments to the health plan to make the directed payments according to this section.

(h) The commissioner of human services must publish on the Department of Human Services website, on a quarterly basis, the dates that the health plans completed their required quarterly payments under this section.

(i) Payments to health plans that would be paid consistent with actuarial certification and enrollment in the absence of the increased capitation payments under this section must not be reduced as a result of this section.

(j) The commissioner must publish all directed payments resulting from this section owed to each eligible hospital from each health plan on the Department of Human Services website for at least two years. All calculations and reports must be posted no later than the first day of the quarter for which the payments are to be issued.

(k) By December 1 each year, the commissioner must notify each eligible hospital of any changes to the payment methodologies in this section, including but not limited to changes in the directed payment rates, the aggregate directed payment amount for all eligible hospitals, and the eligible hospital's directed payment amount for the upcoming calendar year.

(l) The commissioner must pay the amounts to be used for the directed payments to health plans under contract no later than January 1, April 1, July 1, and October 1 each year.

(m) A hospital is not entitled to payments under this section unless it is an eligible hospital. An eligible hospital that has merged with another hospital must have the surviving hospital's payments under this section

revised at the start of the hospital's first full fiscal year after the merger is complete. A closed eligible hospital is entitled to the payments under this section for services provided through the final date of operations.

Subd. 4. **Health plan duties; submission of claims.** Each health plan must submit to the commissioner, in accordance with its contract with the commissioner to serve as a managed care organization in medical assistance, payment information for each claim paid to an eligible hospital for services provided to a medical assistance enrollee. Health plans must allow each eligible hospital to review the health plan's own paid claims detail to enable proper validation that the medical assistance managed care claims volume and content is consistent with the eligible hospital's internal records. To support the validation process for the directed payment program, health plans must permit the commissioner to share inpatient and outpatient claims-level details with eligible hospitals identifying only those claims where the prepaid medical assistance program under section 256B.69 or 256B.692 is the payer source. Eligible hospitals may request claims-level detail once annually and must provide notice of discrepancies in claims paid to the commissioner in a form determined by the commissioner. The commissioner is authorized to determine the final disposition of the validation process for disputed claims.

Subd. 5. **Health plan duties; directed payment add-on.** (a) Each health plan must make, in accordance with its contract with the commissioner to serve as a managed care organization in medical assistance, a directed payment to each eligible hospital. The amount of the directed payment to the eligible hospital must be equal to the payment amounts the plan received from the commissioner for the hospital under this section.

(b) Health plans are prohibited from:

(1) setting, establishing, or negotiating reimbursement rates with an eligible hospital in a manner that directly or indirectly takes into account a directed payment that a hospital receives under this section;

(2) unnecessarily delaying a directed payment to an eligible hospital; or

(3) recouping or offsetting a directed payment for any reason, except as expressly authorized by the commissioner.

Subd. 6. **Hospital duties; quarterly supplemental directed payment add-on.** (a) An eligible hospital receiving a directed payment under this section is prohibited from:

(1) setting, establishing, or negotiating reimbursement rates with a managed care organization in a manner that directly or indirectly takes into account a directed payment that an eligible hospital receives under this section; or

(2) directly passing on the cost of an assessment to patients or nonmedical assistance payers, including as a fee or rate increase.

(b) An eligible hospital that violates this subdivision is prohibited from receiving a directed payment under this section for the remainder of the calendar year. This subdivision does not prohibit an eligible hospital from negotiating with a payer for a rate increase.

Subd. 7. **State minimum policy goals established.** (a) The effect of the directed payments under this section must align with the state's policy goals for medical assistance enrollees. The directed payments must be used to maintain quality and access to a full range of health care delivery mechanisms for medical assistance enrollees, and specifically provide improvement for one of the following quality measures:

(1) overall well child visit rates;

(2) maternal depression screening rates; or

(3) colon cancer screening rates.

(b) The commissioner, in consultation with the Minnesota Hospital Association, must submit to the Centers for Medicare and Medicaid Services quality measures performance evaluation criteria and a methodology to regularly measure access to care and the achievement of state policy goals described in this subdivision.

(c) The quality measures evaluation data, as determined by paragraph (b), must be reported to the Centers for Medicare and Medicaid Services after at least 12 months of directed payments to hospitals.

Subd. 8. **Administrative review.** Before making the payments required under this section, and on at least an annual basis, the commissioner must consult with and provide for review of the payment amounts by a permanent select committee established by the Minnesota Hospital Association. Any data or information reviewed by members of the committee are data not on individuals, as defined in section 13.02. The committee's members may not include any current employee or paid consultant of any hospital.

History: *1Sp2025 c 3 art 8 s 22*

NOTE: This section, as added by Laws 2025, First Special Session chapter 3, article 8, section 22, is effective upon federal approval of the following: (1) the waiver for the assessment required under Minnesota Statutes, section 256.9657, subdivision 2b; and (2) the hospital directed payment program under this section and any conforming changes to the directed payment program under Minnesota Statutes, section 256B.1973. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2025, First Special Session chapter 3, article 8, section 22, the effective date.

256B.1975 HOSPITAL DIRECTED PAYMENT PROGRAM ACCOUNT.

Subdivision 1. **Account established; appropriation.** (a) The hospital directed payment program account is created in the special revenue fund in the state treasury.

(b) Money in the account, including interest earned, is annually appropriated to the commissioner of human services for the purposes specified in section 256B.1974.

(c) Transfers from this account to another fund are prohibited, except as necessary to make the payments required under section 256B.1974.

Subd. 2. **Reports to the legislature.** By January 15, 2027, and each January 15 thereafter, the commissioner must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance that details the activities and uses of money in the hospital directed payment program account, including the metrics and outcomes of the policy goals established by section 256B.1974, subdivision 7.

History: *1Sp2025 c 3 art 8 s 23*

NOTE: This section, as added by Laws 2025, First Special Session chapter 3, article 8, section 23, is effective upon federal approval of the following: (1) the waiver for the assessment required under Minnesota Statutes, section 256.9657, subdivision 2b; and (2) the hospital directed payment program under Minnesota Statutes, section 256B.1974, and any conforming changes to the directed payment program under Minnesota Statutes, section 256B.1973. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2025, First Special Session chapter 3, article 8, section 23, the effective date.

256B.1976 MANAGED CARE ORGANIZATION ASSESSMENT.

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

(b) "Commissioner" means the commissioner of human services.

(c) "Enrollee" has the meaning given in section 62Q.01, except that enrollee does not include:

(1) an individual enrolled in a Medicare plan;

(2) a plan-to-plan enrollee; or

(3) an individual enrolled in a health plan pursuant to the Federal Employees Health Benefits Act of 1959, Public Law 86-382, as amended, to the extent the imposition of the assessment under this section is preempted pursuant to United States Code, title 5, section 8909, subsection (f).

(d) "Managed care organization" or "MCO" means:

(1) an insurance company licensed under chapter 60A to sell health plans as defined in section 62A.011;

(2) a nonprofit health services plan corporation as defined in section 62C.02, subdivision 6;

(3) a health maintenance organization licensed under chapter 62D; or

(4) a county-based purchasing plan participating in a public health care program under chapter 256B or 256L.

(e) "Medical assistance" means the medical assistance program established under chapter 256B.

(f) "Medical assistance enrollee" means an enrollee in medical assistance or MinnesotaCare for whom the Department of Human Services directly pays the managed care organization a capitated payment.

(g) "Member months" means the number of months an enrollee is covered by an MCO in the calendar year immediately preceding the year of the assessment.

(h) "MinnesotaCare" means the MinnesotaCare program established under chapter 256L.

(i) "Plan-to-plan enrollee" means an individual who receives coverage for health care services through a health plan pursuant to a subcontract from another health plan.

Subd. 2. **MCO assessment.** (a) An annual assessment is imposed on managed care organizations for each calendar year beginning in calendar year 2026. The total annual assessment amount is equal to the sum of the amounts assessed for medical assistance enrollees under paragraph (b) and for nonmedical assistance enrollees under paragraph (c).

(b) The amount assessed for medical assistance enrollees is equal to the sum of the following:

(1) for medical assistance member months 0 to 60,000, $0 per member month;

(2) for medical assistance member months 60,001 to 100,000, $340 per member month;

(3) for medical assistance member months 100,001 to 200,000, $365 per member month; and

(4) for medical assistance member months 200,001 to 350,000, $380 per member month.

(c) The amount assessed for nonmedical assistance enrollees is equal to the sum of the following:

(1) for nonmedical assistance member months 0 to 60,000, $0 per member month;

(2) for nonmedical assistance member months 60,001 to 100,000, 50 cents per member month;

(3) for nonmedical assistance member months 100,001 to 200,000, 75 cents per member month; and

(4) for nonmedical assistance member months 200,001 to 350,000, $1 per member month.

(d) The commissioner must annually use the commissioner's authority as necessary to modify the rate of assessment provided under paragraph (e) such that the annual assessment imposed under this subdivision does not exceed the forecasted cumulative costs attributable to the program changes in subdivision 4, paragraph (e), and the appropriation in subdivision 4, paragraph (f).

(e) The commissioner must, after consultation with managed care organizations likely to be affected, modify the rate of assessment, as set forth in paragraphs (a) to (d), as necessary to:

(1) comply with federal law; obtain or maintain a waiver under Code of Federal Regulations, title 42, section 433.72; ensure the state's aggregated health care-related taxes on managed care organizations do not exceed 5.75 percent of the net patient revenue attributable to those services; or otherwise maximize under this section federal financial participation for medical assistance; and

(2) comply with paragraph (d).

Subd. 3. **Assessment computation; collection.** (a) The commissioner must annually forecast the following for each managed care organization:

(1) total member months for the calendar year;

(2) total Medicare member months for the calendar year;

(3) total medical assistance member months for the calendar year;

(4) total plan-to-plan member months for the calendar year;

(5) total member months through the Federal Employees Health Benefits Act of 1959, Public Law 86-382, as amended, for the calendar year; and

(6) total other enrollment for the calendar year that is not otherwise counted in clauses (2) to (5).

(b) Managed care organizations must provide any information requested by the commissioner for the purpose of this subdivision, provided that the commissioner determines such information is necessary to accurately determine the information in paragraph (a).

(c) The commissioner may correct errors in data provided to the commissioner by a managed care organization to the extent necessary to accurately determine the information in paragraph (a).

(d) For purposes of calculating the information in paragraph (a) for a managed care organization, the commissioner must count any individual that was an enrollee of a health plan at any point of the calendar year, regardless of the enrollee's duration as an enrollee of the health plan.

(e) The commissioner must annually use the information in paragraph (a) to compute the assessment for each managed care organization.

(f) The commissioner must collect the annual assessment for each managed care organization in four equal installments, in the manner determined by the commissioner.

(g) Managed care organizations must pay the four installments under paragraph (f) on the following schedule:

(1) the first installment is due by March 31;

(2) the second installment is due by July 31;

(3) the third installment is due by September 30; and

(4) the fourth installment is due by November 30.

(h) The commissioner is prohibited from collecting any amount under this section until 20 days after the commissioner has notified the managed care organization of:

(1) the effective date of this section; and

(2) the annual assessment amount.

(i) In the event of a merger, acquisition, or other transaction that results in the transfer of health plan responsibility to another managed care organization or similar entity, the surviving, acquiring, or controlling managed care organization or similar entity is responsible for paying the full assessment amount as provided in this section that would have been the responsibility of the managed care organization to which that full assessment amount was assessed upon the effective date of the transaction. If a transaction results in the transfer of health plan responsibility for only some of a health plan's enrollees under this section but not all enrollees, the full assessment amount as provided in this section remains the responsibility of the managed care organization to which that full assessment amount was assessed.

(j) The commissioner is prohibited from collecting any assessment under this subdivision during any period of time when the assessment is not considered a permissible health care-related tax under Code of Federal Regulations, title 42, section 433.68, or would result in a net loss of federal financial participation.

Subd. 4. **MCO assessment expenditures.** (a) All amounts collected by the commissioner under this section must be deposited in the special revenue fund.

(b) The arrangement under this section must be implemented in managed care through the prospective capitation rate setting process and must follow all federal requirements, including Code of Federal Regulations, title 42, section 438.5, paragraph (e).

(c) The assessment money must be used to supplement money for medical assistance from the general fund.

(d) The commissioner must disclose to all managed care organizations, in a time and manner determined by the commissioner, the following information:

(1) the assessments imposed on each managed care organization pursuant to this section; and

(2) an accounting of all money raised by the MCO assessment.

(e) All amounts collected by the commissioner under this section, except for the amount necessary for the appropriation under paragraph (f), are annually appropriated from the special revenue fund to the

commissioner to provide nonfederal money for medical assistance and MinnesotaCare program rate changes made in Laws 2025, First Special Session chapter 3, article 8, related to:

(1) behavioral health home services under section 256B.0757;

(2) mental health rates reimbursed under the resource-based relative value scale to 100 percent of the Medicare Physician Fee Schedule under section 256B.76, subdivision 6;

(3) mental health services under section 256B.761; and

(4) mental health services provided by masters-prepared mental health professionals and physician assistants resulting from the repeal of section 256B.0625, subdivision 38.

(f) Reasonable costs for administering the MCO assessment are annually appropriated from the special revenue fund to the commissioner.

(g) A payment rate adjusted under this paragraph may not be lower than the base payment rate for the service in effect on December 31, 2025.

(h) If provider payment rates are adjusted as the result of insufficient revenue from the MCO assessment relative to the medical assistance and MinnesotaCare program changes in paragraphs (e), clauses (1) to (4), and (f), as directed in Laws 2025, First Special Session chapter 3, article 8, the commissioner must:

(1) provide the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance and policy an overview of the changes and recommended statutory language to codify the adjusted payment rate methodology; and

(2) consult with impacted providers and provide a public comment period of at least 30 days prior to seeking federal approval for rate changes.

History: *1Sp2025 c 3 art 8 s 33*

NOTE: This section, as added by Laws 2025, First Special Session chapter 3, article 8, section 33, is effective January 1, 2026, or upon federal approval for the assessment established in this section to be considered a permissible health care-related tax under Code of Federal Regulations, title 42, section 433.68, eligible for federal financial participation, including but not limited to federal approval of a waiver under Code of Federal Regulations, title 42, section 433.72, if such waiver is necessary to receive health care-related taxes without a reduction in federal financial participation, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2025, First Special Session chapter 3, article 8, section 33, the effective date.

256B.198 MS 2024 [Repealed, 2026 c 127 art 5 s 17]

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 (a).

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; 2015 c 21 art 1 s 57*

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 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 (o). 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 payment 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 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; 2015 c 78 art 4 s 61; 1Sp2019 c 10 art 3 s 31*

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*

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:

(1) 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;

(2) payment or grants to a boarding care home or supervised living facility licensed by the Department of Human Services under Minnesota Rules, parts 2960.0130 to 2960.0220, 2960.0580 to 2960.0700, or 9520.0500 to 9520.0670, or under chapter 245G or 245I, or payment to recipients who reside in these facilities;

(3) 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; or

(4) payments or grants otherwise specifically authorized by statute or rule.

Subd. 4. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

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; 2016 c 158 art 1 s 120,214; 2017 c 40 art 1 s 71; 2018 c 182 art 2 s 20; 2021 c 30 art 17 s 107; 2022 c 55 art 1 s 133*

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 administering 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. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

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 in the manner and within the time prescribed by the commissioner 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 commissioner may conduct on-site inspections of any and all vendors and service locations or may request records from a vendor to verify that information submitted to the commissioner is accurate, determine compliance with service delivery and billing requirements, and determine compliance with any other applicable laws or rules. The commissioner must

be given immediate access without prior notice to the vendor's office during regular business hours and to documentation and records related to services provided and submission of claims for services provided. The department shall document in writing the need for immediate access to records related to a specific investigation. Denying the commissioner access to records is cause for the vendor's immediate suspension of payment or termination according to section 256B.064. 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.

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; 1Sp2019 c 9 art 2 s 121; 2023 c 70 art 17 s 47; 2026 c 121 art 4 s 29*

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 MS 2012 [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 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 256R.13, subdivision 1, 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 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; 2017 c 40 art 1 s 72; 1Sp2017 c 6 art 14 s 9*

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 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 and 256L.12 and Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 4, paragraph (c); 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 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; 2016 c 158 art 2 s 98*

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 MS 2022 [Repealed, 2023 c 70 art 4 s 113]

NURSING FACILITY RATES

256B.41 MS 2014 [Repealed, 2016 c 99 art 1 s 43]

256B.411 MS 2014 [Repealed, 2016 c 99 art 1 s 43]

256B.42 MS 1982 [Repealed, 1983 c 199 s 19]

256B.421 DEFINITIONS.

Subdivision 1. **Scope.** For the purposes of this section and sections 256B.431, 256B.434, 256B.48, 256B.50, and 256B.502, the following term has the meaning given to it.

Subd. 2. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 3. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 4. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 5. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 6. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 7. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 8. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 9. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 10. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 11. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 12. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 13. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 14. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 15. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

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; 2016 c 99 art 1 s 43; 2017 c 40 art 1 s 73*

256B.43 MS 1982 [Repealed, 1983 c 199 s 19]

256B.431 RATE DETERMINATION.

Subdivision 1. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 2. MS 1998 [Repealed, 2000 c 449 s 15]

Subd. 2a. MS 1998 [Repealed, 2000 c 449 s 15]

Subd. 2b. MS 2015 Supp [Repealed, 2016 c 99 art 1 s 43]

Subd. 2c. MS 2010 [Repealed, 2012 c 216 art 9 s 38]

Subd. 2d. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 2e. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 2f. MS 1998 [Repealed, 2000 c 449 s 15]

Subd. 2g. MS 2010 [Repealed, 2012 c 216 art 9 s 38]

Subd. 2h. MS 1998 [Repealed, 2000 c 449 s 15]

Subd. 2i. MS 2010 [Repealed, 2012 c 216 art 9 s 38]

Subd. 2j. MS 2010 [Repealed, 2012 c 216 art 9 s 38]

Subd. 2k. MS 2010 [Repealed, 2012 c 216 art 9 s 38]

Subd. 2l. MS 2010 [Repealed, 2012 c 216 art 9 s 38]

Subd. 2m. MS 1998 [Repealed, 2000 c 449 s 15]

Subd. 2n. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 2o. MS 2010 [Repealed, 2012 c 216 art 9 s 38]

Subd. 2p. MS 1998 [Repealed, 2000 c 449 s 15]

Subd. 2q. MS 1998 [Repealed, 2000 c 449 s 15]

Subd. 2r. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 2s. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 2t. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 3. MS 1998 [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;

(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. MS 1998 [Repealed, 2000 c 449 s 15]

Subd. 3c. MS 2010 [Repealed, 2012 c 216 art 9 s 38]

Subd. 3d. MS 1998 [Repealed, 2000 c 449 s 15]

Subd. 3e. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

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 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.

(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. MS 1998 [Repealed, 2000 c 449 s 15]

Subd. 3i. MS 2018 [Repealed, 1Sp2019 c 9 art 4 s 30]

Subd. 3j. MS 1998 [Repealed, 2000 c 449 s 15]

Subd. 4. MS 1998 [Repealed, 2000 c 449 s 15]

Subd. 5. MS 1998 [Repealed, 2000 c 449 s 15]

Subd. 6. MS 1990 [Repealed, 1991 c 292 art 7 s 26]

Subd. 7. MS 1998 [Repealed, 2000 c 449 s 15]

Subd. 8. MS 1998 [Repealed, 2000 c 449 s 15]

Subd. 9. MS 1998 [Repealed, 2000 c 449 s 15]

Subd. 9a. MS 1998 [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. The effective date of the rate adjustment is the first of the month of January or July, whichever occurs first following both the construction project's completion date and submission of the provider's rate adjustment 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 section 144A.071, subdivision 1a.

Subd. 11. MS 2010 [Repealed, 2012 c 216 art 9 s 38]

Subd. 12. MS 1998 [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 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. MS 2010 [Repealed, 2012 c 216 art 9 s 38]

Subd. 15. MS 2018 [Repealed, 1Sp2019 c 9 art 4 s 30]

Subd. 16. MS 2018 [Repealed, 1Sp2019 c 9 art 4 s 30]

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. MS 2010 [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 replacement of buildings, attached fixtures, or land improvements for which the total historical cost exceeds the lesser of $150,000 or ten percent of the most recent appraised value, must be $47,500 per licensed bed in multiple-bed rooms and $71,250 per licensed bed in a single-bed room. These amounts must be adjusted annually as specified in subdivision 3f, paragraph (a), beginning January 1, 1993.

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.

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 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. MS 2010 [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. MS 2010 [Repealed, 2012 c 216 art 9 s 38]

Subd. 20. MS 2010 [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.** 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.

Subd. 23. MS 2008 [Repealed, 2009 c 79 art 8 s 86]

Subd. 24. MS 1998 [Repealed, 2000 c 449 s 15]

Subd. 25. MS 2010 [Repealed, 2012 c 216 art 9 s 38]

Subd. 26. MS 2011 Supp [Repealed, 2012 c 216 art 9 s 38]

Subd. 27. MS 2010 [Repealed, 2012 c 216 art 9 s 38]

Subd. 28. MS 2012 [Repealed, 2014 c 262 art 4 s 9]

Subd. 29. MS 2010 [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. Through December 31, 2026, 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 of January or July, whichever occurs first following the date on 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 or chapter 256R, a nursing facility reimbursed under that section or chapter that 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. Beginning January 1, 2027, a facility is not allowed to change the facility's single bed election; 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 or chapter 256R 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 Minnesota Statutes 2024, section 256B.434, subdivision 4. The property payment rate increase shall be effective the first day of the month of January or July, whichever occurs first following the date on 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).

(d) For the rate years beginning on or after July 1, 2000, notwithstanding any provision to the contrary under section 256B.434 or chapter 256R, a nursing facility reimbursed under that section or chapter that 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. Beginning January 1, 2027, a facility is not allowed to change the facility's single bed election; 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 Minnesota Statutes 2024, section 256B.434, subdivision 4. The property payment rate increase shall be effective the first day of the month of January or July, whichever occurs first following the date on which the delicensure of the beds becomes effective.

(e) For nursing facilities reimbursed under this section, section 256B.434, or chapter 256R, 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, section 256B.434, or chapter 256R, 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 256R.06, subdivision 5.

(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.

(i) The commissioner must not adjust the property payment rates under this subdivision for beds placed in or removed from layaway on or after January 1, 2027.

Subd. 31. MS 2012 [Repealed, 2014 c 262 art 4 s 9]

Subd. 32. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 33. MS 2012 [Repealed, 2014 c 262 art 4 s 9]

Subd. 34. MS 2012 [Repealed, 2014 c 262 art 4 s 9]

Subd. 35. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 36. MS 2015 Supp [Repealed, 2016 c 99 art 1 s 43]

Subd. 37. MS 2012 [Repealed, 2014 c 262 art 4 s 9]

Subd. 38. MS 2012 [Repealed, 2014 c 262 art 4 s 9]

Subd. 39. MS 2012 [Repealed, 2014 c 262 art 4 s 9]

Subd. 40. MS 2012 [Repealed, 2014 c 262 art 4 s 9]

Subd. 41. MS 2012 [Repealed, 2014 c 262 art 4 s 9]

Subd. 42. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 43. MS 2012 [Repealed, 2014 c 262 art 4 s 9]

Subd. 44. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

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; 2015 c 71 art 6 s 7,8; 2016 c 99 art 2 s 5; 1Sp2017 c 6 art 3 s 20-22; art 14 s 10; 1Sp2025 c 9 art 1 s 8; 2026 c 88 art 1 s 131*

256B.432 MS 2014 [Repealed, 2016 c 99 art 1 s 43]

256B.433 Subdivision 1. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 2. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 3. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 3a. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 4. MS 1992 [Repealed, 1993 c 337 s 20]

256B.434 PAYMENT RATES AND PROCEDURES; CONTRACTS AND AGREEMENTS.

Subdivision 1. [Renumbered 256R.03, subd 5]

Subd. 2. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 3. [Renumbered 256R.03, subd 6]

Subd. 4. **Alternate rates for nursing facilities.** Effective for the rate years beginning on and after January 1, 2026, a nursing facility's property payment rate under this section is the facility's previous rate year's property payment rate.

Subd. 4a. MS 2010 [Repealed, 2012 c 216 art 9 s 38]

Subd. 4b. MS 2010 [Repealed, 2012 c 216 art 9 s 38]

Subd. 4c. MS 2010 [Repealed, 2012 c 216 art 9 s 38]

Subd. 4d. MS 2010 [Repealed, 2012 c 216 art 9 s 38]

Subd. 4e. MS 2010 [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, paragraph (c), clause (1). 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. Facilities completing projects after January 1, 2018, are eligible for a property rate adjustment effective on the first day of the month of January or July, whichever occurs immediately 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 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 (c), clause (1). 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 (c), clause (1). 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.

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, paragraph (c), clause (1), 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. MS 2010 [Repealed, 2012 c 216 art 9 s 38]

Subd. 4h. MS 2010 [Repealed, 2012 c 216 art 9 s 38]

Subd. 4i. **Construction project rate adjustments for certain nursing facilities.** (a) This subdivision applies to nursing facilities with at least 120 active beds as of January 1, 2015, that have projects approved in 2015 under the nursing facility moratorium exception process in section 144A.073. When each facility's moratorium exception construction project is completed, the facility must receive the rate adjustment allowed under subdivision 4f. In addition to that rate adjustment, facilities with at least 120 active beds, but not more than 149 active beds, as of January 1, 2015, must have their construction project rate adjustment increased by an additional $4; and facilities with at least 150 active beds, but not more than 160 active beds, as of January 1, 2015, must have their construction project rate adjustment increased by an additional $12.50.

(b) 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 2015 under section 144A.073, subdivision 3, shall be used to reduce the fiscal impact to the medical assistance budget for the increases allowed in this subdivision.

Subd. 4j. **Construction project rate increase for certain nursing facilities.** (a) This subdivision applies to nursing facilities:

(1) located in Ramsey County;

(2) with at least 130 active beds as of September 30, 2017;

(3) with a portion of beds dually certified for Medicare and Medicaid and a portion of beds certified for Medicaid only; and

(4) with debt service payments that are not being covered by the existing property payment rate on September 30, 2017.

(b) The commissioner shall increase the property rate of each facility meeting the qualifications of this subdivision by $7.55.

(c) Notwithstanding any other law to the contrary, money available under section 144A.073, subdivision 15, after the completion of the 2018 moratorium exception approval process under section 144A.073, subdivision 3, shall be used to pay the medical assistance cost for the property rate increase in this subdivision.

Subd. 4k. **Property rate increase for certain nursing facilities.** (a) A rate increase under this subdivision ends upon the effective date of the transition of the facility's property rate to a property payment rate under section 256R.26, subdivision 8.

(b) The commissioner shall increase the property rate of a nursing facility located in the city of St. Paul at 1415 Almond Avenue in Ramsey County by $10.65 on January 1, 2025.

(c) The commissioner shall increase the property rate of a nursing facility located in the city of Duluth at 3111 Church Place in St. Louis County by $20.81 on January 1, 2025.

(d) The commissioner shall increase the property rate of a nursing facility located in the city of Chatfield at 1102 Liberty Street SE in Fillmore County by $21.35 on January 1, 2025.

Subd. 5. MS 2000 [Repealed, 1Sp2001 c 9 art 5 s 41]

Subd. 6. MS 2018 [Repealed, 1Sp2019 c 9 art 4 s 30]

Subd. 7. MS 2010 [Repealed, 2012 c 216 art 9 s 38]

Subd. 8. MS 2010 [Repealed, 2012 c 216 art 9 s 38]

Subd. 9. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 10. MS 2018 [Repealed, 1Sp2019 c 9 art 4 s 30]

Subd. 11. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 12. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 13. MS 2000 [Repealed, 2001 c 161 s 58]

Subd. 14. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 15. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 16. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 17. MS 1998 [Repealed, 1999 c 245 art 3 s 51]

Subd. 18. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 19. MS 2012 [Repealed, 2014 c 262 art 4 s 9]

Subd. 19a. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 19b. MS 2014 [Repealed, 2015 c 71 art 6 s 44]

Subd. 20. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 21. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

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 379 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; 2015 c 71 art 6 s 9,10; 2016 c 99 art 2 s 6; 1Sp2017 c 6 art 3 s 23,24; 2018 c 141 s 1; 1Sp2019 c 9 art 4 s 10,11,29; 2023 c 70 art 3 s 81; 2024 c 125 art 2 s 14; 2024 c 127 art 47 s 14; 1Sp2025 c 9 art 1 s 9,10*

256B.435 MS 2010 [Repealed, 2012 c 216 art 9 s 38]

256B.436 MS 2010 [Repealed, 2012 c 216 art 9 s 38]

256B.437 Subdivision 1. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 2. MS 2002 [Repealed, 1Sp2003 c 14 art 2 s 57]

Subd. 3. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 4. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 5. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 6. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 7. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 8. MS 2012 [Repealed, 2013 c 63 s 20]

Subd. 9. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 10. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

256B.438 MS 2014 [Repealed, 2016 c 99 art 1 s 43]

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, 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 chapter 256S and sections 256B.0625, subdivisions 6a, 7, and 19a; 256B.0913; 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.

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. MS 2022 [Repealed, 2023 c 25 s 190]

Subd. 3c. **Contact and demographic information for consumer surveys for home and community-based services.** For purposes of conducting the consumer surveys under subdivision 3a, the commissioner may request contact information of clients and associated key representatives and aggregate, de-identified demographic information of clients served by the provider. The commissioner may request the following demographic information: (1) age; (2) race; (3) ethnicity; and (4) gender identity. Providers must furnish the contact and demographic information available to the provider and must provide notice to clients and associated key representatives that their contact information and aggregate demographic information has been provided to the commissioner.

Subd. 3d. **Resident experience survey and family survey for assisted living facilities.** The commissioner shall develop and administer a resident experience survey for assisted living facility residents and a family survey for families of assisted living facility residents. Money appropriated to the commissioner to administer the resident experience survey and family survey is available in either fiscal year of the biennium in which it is appropriated. Assisted living facilities licensed under chapter 144G must participate in the surveys when the commissioner requests their participation.

Subd. 3e. **Demographic information for home and community-based services report card.** (a) For purposes of including relevant information in the home and community-based services report card for consumers on the populations served by providers and for other data analysis, the commissioner may request from providers the following summary data about clients served by the provider:

(1) age;

(2) race;

(3) ethnicity; and

(4) gender identity.

(b) For the purposes of this subdivision, "summary data" has the meaning given in section 13.02, subdivision 19. Providers must furnish the summary data only if the data on individuals is available to the provider. A provider is not required to collect any demographic data from clients for the sole purpose of providing the information requested by the commissioner under this subdivision. If a provider furnishes the requested summary data to the commissioner, the provider must provide notice to clients and associated key representatives that the client's demographic information was included in the summary data provided to the commissioner.

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 Hub 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 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; 2019 c 54 art 2 s 34; 1Sp2020 c 2 art 5 s 97; 1Sp2021 c 7 art 13 s 24,25; 2023 c 50 art 1 s 27-29*

256B.44 Subdivision 1. MS 1982 [Repealed, 1983 c 199 s 19]

Subd. 2. MS 1978 [Repealed, 1979 c 336 s 18; 1983 c 199 s 19]

Subd. 3. MS 1982 [Repealed, 1983 c 199 s 19]

256B.440 MS 2012 [Repealed, 2014 c 262 art 4 s 9]

256B.441 Subdivision 1. MS 2015 Supp [Repealed, 2016 c 99 art 1 s 43]

Subd. 2. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 3. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 4. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 5. MS 2015 Supp [Repealed, 2016 c 99 art 1 s 43]

Subd. 6. MS 2015 Supp [Repealed, 2016 c 99 art 1 s 43]

Subd. 7. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 8. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 9. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 10. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 11. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 11a. MS 2015 Supp [Repealed, 2016 c 99 art 1 s 43]

Subd. 12. MS 2006 [Repealed, 2007 c 147 art 7 s 76]

Subd. 13. MS 2015 Supp [Repealed, 2016 c 99 art 1 s 43]

Subd. 14. MS 2015 Supp [Repealed, 2016 c 99 art 1 s 43]

Subd. 14a. MS 2014 [Repealed, 2015 c 71 art 6 s 44]

Subd. 15. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 16. MS 2006 [Repealed, 2007 c 147 art 7 s 76]

Subd. 17. MS 2015 Supp [Repealed, 2016 c 99 art 1 s 43]

Subd. 18. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 19. MS 2014 [Repealed, 2015 c 71 art 6 s 44]

Subd. 20. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 21. MS 2006 [Repealed, 2007 c 147 art 7 s 76]

Subd. 22. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 23. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 24. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 25. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 26. MS 2006 [Repealed, 2007 c 147 art 7 s 76]

Subd. 27. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 28. MS 2006 [Repealed, 2007 c 147 art 7 s 76]

Subd. 28a. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 29. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 30. MS 2015 Supp [Repealed, 2016 c 99 art 1 s 43]

Subd. 31. MS 2015 Supp [Repealed, 2016 c 99 art 1 s 43]

Subd. 32. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 33. MS 2015 Supp [Repealed, 2016 c 99 art 1 s 43]

Subd. 33a. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 34. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 35. MS 2015 Supp [Repealed, 2016 c 99 art 1 s 43]

Subd. 36. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 37. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 38. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 39. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 40. MS 2015 Supp [Repealed, 2016 c 99 art 1 s 43]

Subd. 41. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 42. MS 2006 [Repealed, 2007 c 147 art 7 s 76]

Subd. 42a. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 43. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 44. MS 2015 Supp [Repealed, 2016 c 99 art 1 s 43]

Subd. 45. MS 2006 [Repealed, 2007 c 147 art 7 s 76]

Subd. 46. MS 2012 [Repealed, 2014 c 262 art 4 s 9]

Subd. 46a. MS 2012 [Repealed, 2014 c 262 art 4 s 9]

Subd. 46b. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 46c. MS 2015 Supp [Repealed, 2016 c 99 art 1 s 43]

Subd. 46d. MS 2015 Supp [Repealed, 2016 c 99 art 1 s 43]

Subd. 47. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 48. MS 2015 Supp [Repealed, 2016 c 99 art 1 s 43]

Subd. 49. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 50. MS 2015 Supp [Repealed, 2016 c 99 art 1 s 43]

Subd. 50a. MS 2014 [Repealed, 2015 c 71 art 6 s 44]

Subd. 51. MS 2015 Supp [Repealed, 2016 c 99 art 1 s 43]

Subd. 51a. MS 2015 Supp [Repealed, 2016 c 99 art 1 s 43]

Subd. 51b. MS 2015 Supp [Repealed, 2016 c 99 art 1 s 43]

Subd. 52. MS 2014 [Repealed, 2015 c 71 art 6 s 44]

Subd. 53. MS 2015 Supp [Repealed, 2016 c 99 art 1 s 43]

Subd. 54. MS 2015 Supp [Repealed, 2016 c 99 art 1 s 43]

Subd. 55. MS 2014 [Repealed, 2015 c 71 art 6 s 44]

Subd. 55a. MS 2015 Supp [Repealed, 2016 c 99 art 1 s 43]

Subd. 56. MS 2015 Supp [Repealed, 2016 c 99 art 1 s 43]

Subd. 57. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 58. MS 2014 [Repealed, 2015 c 71 art 6 s 44]

Subd. 59. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 60. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 61. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 62. MS 2014 [Repealed, 2015 c 71 art 6 s 44]

Subd. 63. MS 2015 Supp [Repealed, 2016 c 99 art 1 s 43]

Subd. 64. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 65. MS 2015 Supp [Repealed, 2016 c 99 art 1 s 43]

Subd. 66. MS 2015 Supp [Repealed, 2016 c 99 art 1 s 43]

Subd. 67. MS 2015 Supp [Repealed, 2016 c 99 art 1 s 43]

256B.45 MS 1982 [Repealed, 1983 c 199 s 19]

256B.46 MS 1982 [Repealed, 1983 c 199 s 19]

256B.47 MS 2014 [Repealed, 2016 c 99 art 1 s 43]

256B.48 CONDITIONS FOR PARTICIPATION.

Subdivision 1. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 1a. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 1b. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 1c. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 2. **Reporting requirements.** (a) No later than December 31 of each year, an 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;

(2) provide the state agency with a statement of ownership for the facility;

(3) provide the state agency with separate, audited financial statements 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 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 facility; and

(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.

(b) Audited financial statements submitted under paragraph (a) 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 report. Certified public accountants must conduct audits in accordance with chapter 326A. The cost of an audit shall not be an allowable cost unless the intermediate care facility submits its audited financial statements in the manner otherwise specified in this subdivision. An intermediate care facility must permit access by the state agency to the certified public accountant's work papers that support the audited financial statements submitted under paragraph (a).

(c) Documents or information provided to the state agency pursuant to this subdivision shall be public.

(d) If the requirements of paragraphs (a) and (b) 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 period and the reduction shall continue until the requirements are met.

(e) 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. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 3a. **Audit adjustments.** If the commissioner requests supporting documentation during an audit for an item of cost reported by an intermediate care facility, and the 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 facility's appeal rights.

Subd. 4. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 5. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 6. MS 2010 [Repealed, 2012 c 247 art 4 s 51]

Subd. 6a. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 7. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 8. MS 2014 [Repealed, 2016 c 99 art 1 s 43]

Subd. 9. MS 1998 [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; 2016 c 99 art 2 s 7,8*

256B.49 HOME AND COMMUNITY-BASED SERVICE WAIVERS FOR PERSONS WITH DISABILITIES.

Subdivision 1. MS 2000 [Repealed, 1Sp2001 c 9 art 3 s 76]

Subd. 2. MS 2000 [Repealed, 1Sp2001 c 9 art 3 s 76]

Subd. 3. MS 2000 [Repealed, 1Sp2001 c 9 art 3 s 76]

Subd. 4. MS 2000 [Repealed, 1Sp2001 c 9 art 3 s 76]

Subd. 5. MS 2000 [Repealed, 1Sp2001 c 9 art 3 s 76]

Subd. 6. MS 2000 [Repealed, 1Sp2001 c 9 art 3 s 76]

Subd. 7. MS 2000 [Repealed, 1Sp2001 c 9 art 3 s 76]

Subd. 8. MS 2000 [Repealed, 1Sp2001 c 9 art 3 s 76]

Subd. 9. MS 2000 [Repealed, 1Sp2001 c 9 art 3 s 76]

Subd. 10. MS 2000 [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 federal 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 waiver 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 federal 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.

(f) The commissioner shall comply with the requirements in the federally approved transition plan for the home and community-based services waivers authorized under this section.

(g) The commissioner shall seek federal approval to allow for the reconfiguration of the 1915(c) home and community-based waivers in this section, as authorized under section 1915(c) of the federal Social Security Act, to implement a two-waiver program structure.

(h) The commissioner shall seek federal approval for the 1915(c) home and community-based waivers in this section, as authorized under section 1915(c) of the federal Social Security Act, to implement an individual resource allocation methodology.

[See Note.]

Subd. 11a. **Waiver services statewide priorities.** (a) The commissioner shall establish statewide priorities for individuals on the waiting list for community alternative care, community access for disability inclusion, 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 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 new enrollment resources to lead agencies, the commissioner must take into consideration the number of individuals waiting who meet statewide priorities.

[See Note.]

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 26, 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 person-centered written support plan within the timelines established by the commissioner and section 256B.0911, subdivision 29;

(2) informing the recipient or the recipient's legal guardian or conservator of service options, including all service options available under the waiver plans;

(3) assisting the recipient in the identification of potential service providers of chosen services, including:

(i) available options for case management service and providers;

(ii) providers of services provided in a non-disability-specific setting;

(iii) employment service providers;

(iv) providers of services provided in settings that are not community residential settings; and

(v) providers of financial management services;

(4) assisting the recipient to access services and assisting with appeals under section 256.045;

(5) coordinating, evaluating, and monitoring of the services identified in the service plan; and

(6) assisting and cooperating with facilities licensed under chapter 144G with the licensee's obligations under section 144G.55.

(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:

(1) finalizing the person-centered support plan;

(2) ongoing assessment and monitoring of the person's needs and adequacy of the approved person-centered support plan; and

(3) adjustments to the person-centered 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. If a county agency provides case management under contracts with other individuals or agencies and the county agency utilizes a competitive proposal process for the procurement of contracted case management services, the competitive proposal process must include evaluation criteria to ensure that the county maintains a culturally responsive program for case management services adequate to meet the needs of the population of the county. For the purposes of this section, "culturally responsive program" means a case management services program that: (1) ensures effective, equitable, comprehensive, and respectful quality care services that are responsive to individuals within a specific population's values, beliefs, practices, health literacy, preferred language, and other communication needs; and (2) is designed to address the unique needs of individuals who share a common language or racial, ethnic, or social background.

(d) 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 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 10.

(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 20 hours of case management education and disability-related training each year. The education and training must include appropriate service authorization, person-centered planning, informed choice, informed decision making, cultural competency, employment planning, community living planning, self-direction options, and use of technology supports. Case managers must annually complete an informed choice curriculum and pass a competency evaluation, in a form determined by the commissioner, on informed decision-making standards. By August 1, 2024, all case managers must complete an employment support training course identified by the commissioner of human services. For case managers hired after August 1, 2024, this training must be completed within the first six months of providing case management services. For the purposes of this section, "person-centered planning" or "person-centered" has the meaning given in section 256B.0911, subdivision 10. Case managers shall document completion of training in a system identified by the commissioner.

Subd. 14. **Assessment and reassessment.** (a) Assessments and reassessments shall be conducted by certified assessors according to section 256B.0911, subdivisions 13 and 14.

(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 26, 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 assessments conducted according to section 256B.0911, subdivisions 17 to 21, 23, 24, and 27 to 31, 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.

(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. **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 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.

(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 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.

Subd. 16. **Services and supports.** (a) Services and supports included in the home and community-based waivers for persons with disabilities must 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, must promote consumer choice, community inclusion, self-sufficiency, and self-determination.

(b) The commissioner must simplify and improve access to home and community-based waiver 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 supports must be offered as an option to all persons eligible for services under subdivision 11.

(d) Services and supports must be arranged and provided consistent with individualized written plans of care for eligible waiver recipients.

(e) The state of Minnesota and county agencies that administer home and community-based waiver services for persons with disabilities must 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 consumer-directed community supports 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. MS 2012 [Repealed, 2013 c 108 art 9 s 16]

Subd. 16b. **Authorization of technology services.** (a) Lead agencies must not implement additional requirements, in addition to those required by the commissioner, that could result in the delay of approval or implementation of technology.

(b) For individuals receiving waiver services under this section, approval or denial of technology must occur within 30 business days of the receipt of the initial request. If denied, the lead agency must submit a notice of action form clearly stating the reason for the denial, including information describing why the technology is not appropriate to meet the individual's assessed need.

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) 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.

(c) 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.

[See Note.]

Subd. 17a. **Service authorizations and service agreements.** (a) Recipients must be screened and authorized for services according to the federally approved waiver application and its subsequent amendments.

(b) The commissioner must require lead agency supervisors to review and accept all service agreements entered by lead agency staff into the Medicaid management information system (MMIS) prior to the commissioner's approval of the service agreement.

(c) For a service agreement with a proposed total authorized amount that exceeds the total authorized amount in the recipient's prior service agreement by more than the value of legislatively enacted rate increases, the commissioner must manually review and manually approve the service agreement in the MMIS. For purposes of this paragraph, "prior service agreement" means the service agreement that was in effect 12 months prior to the start date of the new proposed service agreement.

(d) In a format prescribed by the commissioner, lead agencies must submit the following information for all service agreements subject to the commissioner's approval in paragraph (c):

(1) changes in the number of units authorized;

(2) new services authorized;

(3) changes in the values used to calculate service rates under section 256B.4914, except for automatic adjustments required under section 256B.4914, subdivisions 5 and 5b;

(4) changes in the person's level of need that require an increase in the amount of services authorized;

(5) documentation detailing why the previous amount of services is not sufficient to meet the person's needs; and

(6) anticipated impact if the total service amount is not increased to the proposed amount.

(e) Except for rate increases required under section 256B.4914, subdivisions 5 and 5b, and rate changes authorized by the 2025 legislature, the commissioner must not approve service agreements under paragraph

(c) that are not the result of either a documented change in a person's assessed needs or documented evidence that the previous level of service was insufficient to meet the person's assessed needs.

(f) This subdivision expires upon full implementation of waiver reimagine. The commissioner must inform the revisor of statutes when waiver reimagine is fully implemented.

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).

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. MS 2022 [Repealed, 2023 c 50 art 1 s 38]

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 access for disability inclusion, 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 7c.

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 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 245I.24, subdivision 9; 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.

[See Note.]

Subd. 26. **Excess allocations.** Effective July 1, 2018, county and Tribal agencies will be responsible for spending in excess of the annual 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, the county or Tribal agency must submit a corrective action plan to the commissioner for approval. The plan must state the actions the agency will take to correct its overspending for the two years following the period when the overspending occurred. The commissioner shall recoup funds spent in excess of the allocation only in cases when statewide spending exceeds the appropriation designated for the home and community-based services waivers. Nothing in this subdivision shall be construed as reducing the county or Tribe's responsibility to offer and make available feasible home and community-based options to eligible waiver recipients within the resources allocated to it for that purpose.

[See Note.]

Subd. 27. **Use of waiver allocations.** (a) Effective until June 30, 2018, county and Tribal agencies are responsible for authorizing the annual allocation made by the commissioner. In the event a county or Tribal agency authorizes less than 97 percent of the allocation, while maintaining a list of persons waiting for waiver services, the county or Tribal agency must submit a corrective action plan to the commissioner for approval. The commissioner may determine a plan is unnecessary given the size of the allocation and capacity for new enrollment. The plan must state the actions the agency will take to assure reasonable and timely access to home and community-based waiver services for persons waiting for services.

(b) Effective July 1, 2018, county and Tribal agencies are responsible for spending the annual allocation made by the commissioner. In the event a county or Tribal agency spends less than 97 percent of the allocation, while maintaining a list of persons waiting for waiver services, the county or Tribal agency must submit a corrective action plan to the commissioner for approval. The commissioner may determine a plan is unnecessary given the size of the allocation and capacity for new enrollment. The plan must state the actions the agency will take to assure reasonable and timely access to home and community-based waiver services for persons waiting for services.

(c) If a county or Tribe does not submit a plan when required or implement the changes required, the commissioner shall assure access to waiver services within the county or Tribe's available allocation, and

take other actions needed to assure that all waiver participants in that county or Tribe are receiving appropriate waiver services to meet their needs.

[See Note.]

Subd. 28. **Customized living moratorium for brain injury and community access for disability inclusion waivers.** (a) Notwithstanding section 245A.03, subdivision 2, paragraph (a), clause (18), to prevent new development of customized living settings that otherwise meet the residential program definition under section 245A.02, subdivision 14, the commissioner shall not enroll new customized living settings serving four or fewer people in a single-family home to deliver customized living services as defined under the brain injury or community access for disability inclusion waiver plans under this section.

(b) The commissioner may approve an exception to paragraph (a) when an existing customized living setting changes ownership at the same address.

(c) Customized living settings operational on or before June 30, 2021, are considered existing customized living settings.

(d) For any new customized living settings serving four or fewer people in a single-family home to deliver customized living services as defined in paragraph (a) and that was not operational on or before June 30, 2021, the authorizing lead agency is financially responsible for all home and community-based service payments in the setting.

(e) For purposes of this subdivision, "operational" means customized living services are authorized and delivered to a person in the customized living setting.

Subd. 28a. **Transfer of customized living enrollment dates.** (a) For the purposes of this subdivision, "operational" has the meaning given in subdivision 28.

(b) This paragraph applies only to customized living settings enrolled and operational on or before June 30, 2021, and customized living settings that have previously transferred their customized living enrollment date under this paragraph. A provider that receives approval from the commissioner of health under section 144G.195, subdivision 1, to relocate a licensed assisted living facility that was enrolled prior to January 11, 2021, to deliver medical assistance 24-hour customized living services, or customized living services as defined by the brain injury and community access for disability inclusion federally approved home and community-based services waiver plans, may continue to operate the customized living setting under the original setting's customized living enrollment date if all of the requirements under this subdivision are met.

(c) A transfer of enrollment date is allowed under this subdivision only if the facility relocation is due to:

(1) a provider that rents the original setting being unable to continue to rent the original setting because of eviction, nonrenewal of its lease by the property owner, or sale of the property by the owner;

(2) a provider that rents the original setting being unable to make the necessary updates or improvements to the original setting to comply with the physical plant and other requirements under state or federal law, including but not limited to chapter 144G;

(3) a provider's monthly rent increasing more than three percent in a 12-month period;

(4) the original setting being destroyed or damaged by fire, lightning, flood, wind, ground shifts, or other such hazards, including environmental hazards, to such an extent that the original setting cannot be repaired and the safety of residents would be jeopardized by continuing to reside in the original setting; or

(5) a provider or an entity that directly or indirectly through one or more intermediaries is controlled by, is under common control with, or controls the entity enrolled to provide customized living services at the current setting purchases a new setting and the commissioner of health approves the relocation of the provider's assisted living facility license to the newly purchased setting.

(d) When a relocation is necessitated by a qualifying situation under paragraph (c), clauses (1) to (5), the provider must submit a notification to the commissioner of human services, the ombudsman of long-term care, the ombudsperson of mental health and developmental disabilities, relevant lead agencies, each resident's case manager, and either each person receiving services at the setting or the person's legal representative. The notification must be made at least 30 days prior to the relocation date and on forms and in the manner prescribed by the commissioner of human services.

(e) A provider proposing to transfer a customized living setting enrollment date to a new setting must submit, with the provider's notification to the commissioner of human services under paragraph (d), the following information:

(1) the addresses of the vacating location and of the proposed new location;

(2) the anticipated date of the move to the new location;

(3) contacts for the lead agency and each resident's waiver case manager;

(4) documentation that the Department of Health has received an application to relocate pursuant to section 144G.195, subdivision 1, for the new location; and

(5) documentation that the customized living provider's assisted living facility license is not conditional.

(f) The commissioner of human services has 30 days to approve or deny requests to transfer the original setting's customized living enrollment date to the new setting.

(g) The commissioner of human services must deny requests to transfer a customized living enrollment date to a new setting if:

(1) the new setting approved by the commissioner of health under section 144G.195, subdivision 1, is adjoined to or on the same property as an institution as defined in Code of Federal Regulations, title 42, section 441.301(c), or one or more licensed assisted living facilities;

(2) the requesting provider fails to notify the commissioner of human services of the proposed relocation within the time frames required under this subdivision;

(3) the requesting provider's assisted living facility license is conditional; or

(4) the requesting provider is changing ownership at the same time as the proposed relocation.

(h) The setting to which the original customized living enrollment date is transferred must:

(1) comply with setting requirements in the brain injury and community access for disability inclusion federally approved home and community-based services waiver plans and under this section as the requirements existed on the customized living enrollment date of the original setting;

(2) have a resident capacity less than or equal to the resident capacity of the original setting;

(3) not require or coerce any resident of the original setting to move to the new setting, consistent with informed choice and independent living policies under section 256B.4905, subdivisions 1a, 2a, 3a, and 8; and

(4) provide each resident with a new assisted living contract and comply with the coordinated move requirements under section 144G.55.

Subd. 29. **Residential support services criteria.** (a) For the purposes of this subdivision, "residential support services" means the following residential support services reimbursed under section 256B.4914: community residential services, customized living services, and 24-hour customized living services.

(b) In order to increase independent living options for people with disabilities and in accordance with section 256B.4905, subdivisions 7 and 8, and consistent with section 245A.03, subdivisions 7b to 7d, the commissioner must establish and implement criteria to access residential support services. The criteria for accessing residential support services must prohibit the commissioner from authorizing residential support services unless at least all of the following conditions are met:

(1) the individual has complex behavioral health or complex medical needs; and

(2) the individual's service planning team has considered all other available residential service options and determined that those options are inappropriate to meet the individual's support needs.

(c) Nothing in this subdivision shall be construed as permitting the commissioner to establish criteria prohibiting the authorization of residential support services for individuals described in the statewide priorities established in subdivision 11a, the transition populations in subdivision 24, and the licensing moratorium exception criteria under section 245A.03, subdivision 7b.

(d) Individuals with active service agreements for residential support services on the date that the criteria for accessing residential support services become effective are exempt from the requirements of this subdivision, and the exemption from the criteria for accessing residential support services continues to apply for renewals of those service agreements.

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; 2015 c 71 art 7 s 33,34; 2015 c 78 art 6 s 31; 2017 c 90 s 19; 1Sp2017 c 6 art 2 s 14,15; 2019 c 50 art 1 s 75; 1Sp2019 c 9 art 5 s 52,53; 1Sp2020 c 2 art 2 s 29; art 4 s 8-10; 1Sp2021 c 7 art 6 s 24; art 13 s 26-30; 2022 c 98 art 17 s 15-17,26; 2023 c 61 art 1 s 20; 2024 c 108 art 1 s 16; 2024 c 125 art 1 s 20,21; art 2 s 15; 2024 c 127 art 46 s 20,21; art 47 s 15; 2025 c 38 art 1 s 18,19; 1Sp2025 c 9 art 2 s 26-28; art 8 s 16; 2026 c 95 art 4 s 41; 2026 c 121 art 8 s 15*

NOTE: The amendment to subdivision 11 by Laws 2021, First Special Session chapter 7, article 13, section 26, is effective 90 days after federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2021, First Special Session chapter 7, article 13, section 26, the effective date.

NOTE: The amendments to subdivisions 11a and 17 by Laws 2021, First Special Session chapter 7, article 13, sections 27 and 28, are effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2021, First Special Session chapter 7, article 13, sections 27 and 28, the effective dates.

NOTE: The amendment to subdivision 25 by Laws 2026, chapter 121, article 8, section 15, is effective January 1, 2028. Laws 2026, chapter 121, article 8, section 17.

NOTE: Subdivisions 26 and 27 are repealed by Laws 2021, First Special Session chapter 7, article 13, section 79, effective upon federal approval. The commissioner of human services shall inform the revisor of statutes when federal approval is obtained. Laws 2021, First Special Session chapter 7, article 13, section 79.

256B.4905 HOME AND COMMUNITY-BASED SERVICES POLICY STATEMENT.

Subdivision 1. MS 2020 [Repealed, 1Sp2021 c 7 art 13 s 79]

Subd. 1a. **Informed choice.** For purposes of this section, "informed choice" means a choice that adults who have disabilities and, with support from their families or legal representatives, that children who have disabilities make regarding services and supports that best meets the adult's or children's needs and preferences. Before making an informed choice, an individual who has disabilities must be provided, in an accessible format and manner that meets the individual's needs, the tools, information, and opportunities that the individual requires to understand all of the individual's options.

Subd. 2. MS 2020 [Repealed, 1Sp2021 c 7 art 13 s 79]

Subd. 2a. **Informed choice policy.** (a) It is the policy of this state that all adults who have disabilities and, with support from their families or legal representatives, that all children who have disabilities:

(1) may make informed choices to select and utilize disability services and supports; and

(2) are offered an informed decision-making process sufficient to make informed choices.

(b) It is the policy of this state that disability waivers services support the presumption that adults who have disabilities and, with support from their families or legal representatives, all children who have disabilities may make informed choices; and that all adults who have disabilities and all families of children who have disabilities and are accessing waiver services under sections 256B.092 and 256B.49 are provided an informed decision-making process that satisfies the requirements of subdivision 3a.

(c) Lead agencies must support individuals in making informed choices by:

(1) providing complete and accurate information about available home and community-based services and settings;

(2) providing the information in a manner that is culturally and linguistically appropriate; and

(3) facilitating access to services that reflect the individual's preferences and assessed needs.

(d) For individuals who are members of or affiliated with a federally recognized Tribal Nation located within Minnesota, informed choice includes the right to receive services administered or provided by the individual's Tribal Nation. Lead agencies must:

(1) inform individuals of services offered by Tribal Nations enrolled as Minnesota health care providers;

(2) directly coordinate with the individual's Tribal Nation human services agency when the individual seeks or may be eligible for services administered or provided by that Tribal Nation; and

(3) ensure that service planning and delivery respects the individual's rights as both a member of a sovereign Tribal Nation and a resident of Minnesota.

(e) County lead agencies and Tribal Nation human services agencies must establish and maintain procedures to share updated contact information, coordinate case management, and provide timely referrals necessary to ensure that informed choice is fully exercised.

(f) Nothing in this section limits the sovereignty of Tribal Nations or the authority of Tribal governments to administer home and community-based services to their members.

Subd. 3. MS 2020 [Repealed, 1Sp2021 c 7 art 13 s 79]

Subd. 3a. **Informed decision making.** "Informed decision making" means a process that provides accessible, correct, and complete information to help an individual who is accessing waiver services under sections 256B.092 and 256B.49 make an informed choice. This information must be accessible and understandable to the individual so that the individual is able to demonstrate understanding of the options. Any written information provided in the process must be accessible and the process must be experiential whenever possible. The process must also consider and offer to the individual, in a person-centered manner, the following:

(1) reasonable accommodations as needed or requested by the individual to fully participate in the informed decision-making process and acquire the information necessary to make an informed choice;

(2) discussion of the individual's own preferences, abilities, goals, and objectives;

(3) identification of the person's cultural needs and access to culturally responsive services and providers;

(4) information about the benefits of inclusive and individualized services and supports;

(5) presentation and discussion of all options with the person;

(6) documentation, in a manner prescribed by the commissioner, of each option discussed;

(7) exploration and development of new or other options;

(8) facilitation of opportunities to visit alternative locations or to engage in experiences to understand how any service option might work for the person;

(9) opportunities to meet with other individuals with disabilities who live, work, and receive services different from the person's own services;

(10) development of a transition plan, when needed or requested by the person, to facilitate the choice to move from one service type or setting to another, and authorization of the services and supports necessary to effectuate the plan;

(11) identification of any barriers to assisting or implementing the person's informed choice and authorization of the services and supports necessary to overcome those barriers; and

(12) ample time and timely opportunity to consider available options before the individual makes a final choice or changes a choice.

Subd. 4. MS 2020 [Repealed, 1Sp2021 c 7 art 13 s 79]

Subd. 4a. **Informed choice in employment policy.** It is the policy of this state that working-age individuals who have disabilities:

(1) can work and achieve competitive integrated employment with appropriate services and supports, as needed;

(2) make informed choices about their postsecondary education, work, and career goals;

(3) will be offered the opportunity to make an informed choice, at least annually, to pursue postsecondary education or to work and earn a competitive wage; and

(4) will be offered benefits planning assistance and supports to understand available work incentive programs and to understand the impact of work on benefits.

Subd. 5. MS 2020 [Repealed, 1Sp2021 c 7 art 13 s 79]

Subd. 5a. **Employment first implementation for disability waiver services.** The commissioner of human services shall ensure that:

(1) the disability waivers under sections 256B.092 and 256B.49 support the presumption that all working-age Minnesotans with disabilities can work and achieve competitive integrated employment with appropriate services and supports, as needed; and

(2) each waiver recipient of working age be offered, after an informed decision-making process and during a person-centered planning process, the opportunity to work and earn a competitive wage before being offered exclusively day services as defined in section 245D.03, subdivision 1, paragraph (c), clause (4), or successor provisions.

Subd. 6. MS 2020 [Repealed, 1Sp2021 c 7 art 13 s 79]

Subd. 7. **Informed choice in community living policy.** It is the policy of this state that all adults who have disabilities:

(1) can live in the communities of the individual's choosing with appropriate services and supports as needed; and

(2) have the right, at least annually, to make an informed decision-making process that can help them make an informed choice to live outside of a provider-controlled setting.

Subd. 8. **Independent living first implementation for disability waiver services.** The commissioner of human services shall ensure that:

(1) the disability waivers under sections 256B.092 and 256B.49 support the presumption that all adults who have disabilities can and want to live in the communities of the individual's choosing with services and supports, as needed; and

(2) each adult waiver recipient is offered, after an informed decision-making process and during a person-centered planning process, the opportunity to live as independently as possible, in a nonprovider-controlled setting, before the recipient is offered a provider-controlled setting. A provider-controlled setting includes customized living services provided in a single-family home or residential supports and services as defined in section 245D.03, subdivision 1, paragraph (c), clause (3), or successor provisions, unless the residential supports and services are provided in a family adult foster care residence under a shared-living option as described in Laws 2013, chapter 108, article 7, section 62.

Subd. 9. **Informed choice in self-direction policy.** It is the policy of this state that adults who have disabilities and families of children who have disabilities:

(1) can direct the adult's or child's needed services and supports; and

(2) have the right to make an informed choice to self-direct the adult's or child's services and supports before being offered options that do not allow the adult or family to self-direct the adult's or child's services and supports.

Subd. 10. **Informed choice in self-direction implementation for disability waiver services.** The commissioner of human services shall ensure that:

(1) disability waivers under sections 256B.092 and 256B.49 support the presumption that adults who have disabilities and families of children who have disabilities can direct all of their services and supports, including self-directed funding options; and

(2) each waiver recipient is offered, after an informed decision-making process and during a person-centered planning process, the opportunity to choose self-directed services and supports, including self-directed funding options, before the recipient is offered services and supports that are not self-directed.

Subd. 11. **Informed choice in technology policy.** It is the policy of this state that all adults who have disabilities and children who have disabilities:

(1) can use assistive technology, remote supports, or a combination of both to enhance the adult's or child's independence and quality of life; and

(2) have the right, at least annually, to make an informed choice about the adult's or child's use of assistive technology and remote supports.

Subd. 12. **Informed choice and technology prioritization in implementation for disability waiver services.** The commissioner of human services shall ensure that:

(1) disability waivers under sections 256B.092 and 256B.49 support the presumption that all adults who have disabilities and children who have disabilities may use assistive technology, remote supports, or both to enhance the adult's or child's independence and quality of life; and

(2) each individual accessing waiver services is offered, after an informed decision-making process and during a person-centered planning process, the opportunity to choose assistive technology, remote support, or both prior to the commissioner offering or reauthorizing services that utilize direct support staff to ensure equitable access.

History: *1Sp2020 c 2 art 3 s 1; 1Sp2021 c 7 art 13 s 31-41; 2023 c 61 art 1 s 21; 2024 c 108 art 1 s 17; 2026 c 95 art 4 s 27*

256B.4906 SUBMINIMUM WAGES IN HOME AND COMMUNITY-BASED SERVICES REPORTING.

(a) A provider of home and community-based services for people with developmental disabilities under section 256B.092 or home and community-based services for people with disabilities under section 256B.49 that holds a credential listed in clause (1) or (2) as of August 1, 2023, must submit to the commissioner of human services data on individuals who are currently being paid subminimum wages or were being paid subminimum wages by the provider organization as of August 1, 2023:

(1) a certificate through the United States Department of Labor under United States Code, title 29, section 214(c), of the Fair Labor Standards Act authorizing the payment of subminimum wages to workers with disabilities; or

(2) a permit by the Minnesota Department of Labor and Industry under section 177.28.

(b) The report required under paragraph (a) must include the following data about each individual being paid subminimum wages:

(1) name;

(2) date of birth;

(3) identified race and ethnicity;

(4) disability type;

(5) key employment status measures as determined by the commissioner; and

(6) key community-life engagement measures as determined by the commissioner.

(c) The information in paragraph (b) must be submitted in a format determined by the commissioner.

(d) A provider must submit the data required under this section annually on a date specified by the commissioner. The commissioner must give a provider at least 30 calendar days to submit the data following notice of the due date. If a provider fails to submit the requested data by the date specified by the commissioner, the commissioner may delay medical assistance reimbursement until the requested data is submitted.

(e) Individually identifiable data submitted to the commissioner under this section are considered private data on individuals as defined by section 13.02, subdivision 12.

(f) The commissioner must analyze data annually for tracking employment and community-life engagement outcomes.

History: *2023 c 61 art 1 s 22*

256B.4907 ADVISORY TASK FORCE ON WAIVER REIMAGINE.

Subdivision 1. **Membership; co-chairs.** (a) The Advisory Task Force on Waiver Reimagine consists of the following members:

(1) one member of the house of representatives, appointed by the speaker of the house;

(2) one member of the house of representatives, appointed by the leader of the house of representatives Democratic-Farmer-Labor caucus;

(3) one member of the senate, appointed by the senate majority leader;

(4) one member of the senate, appointed by the senate minority leader;

(5) four individuals currently receiving disability waiver services who are under the age of 65, appointed by the governor;

(6) one county employee who conducts long-term care consultation services assessments for persons under the age of 65, appointed by the Minnesota Association of County Social Services Administrators;

(7) one representative of the Department of Human Services with knowledge of the requirements for a provider to participate in disability waiver service programs and of the administration of benefits, appointed by the commissioner of human services;

(8) one employee of the Minnesota Council on Disability, appointed by the Minnesota Council on Disability;

(9) two representatives of disability advocacy organizations, appointed by the governor;

(10) two family members of individuals who are receiving disability waiver services, appointed by the governor;

(11) two providers of disability waiver services for persons who are under the age of 65, appointed by the governor;

(12) one employee from the Office of Ombudsman for Mental Health and Developmental Disabilities, appointed by the ombudsman;

(13) one employee from the Olmstead Implementation Office, appointed by the director of the office;

(14) the assistant commissioner of the Department of Human Services administration that oversees disability services; and

(15) a member of the Minnesota Disability Law Center, appointed by the executive director of Mid-Minnesota Legal Aid.

(b) Each appointing authority must make appointments by September 30, 2025. Appointments made by an agency or commissioner may also be made by a designee.

(c) In making task force appointments, the governor must ensure representation from greater Minnesota.

(d) The Office of Collaboration and Dispute Resolution must convene the task force.

(e) The task force members must elect co-chairs from the membership of the task force at the first task force meeting.

Subd. 2. **Meetings; administrative support.** (a) The first meeting of the task force must be convened no later than November 30, 2025. The task force must meet at least quarterly. Meetings are subject to chapter 13D. The task force may meet by telephone or interactive technology consistent with section 13D.015.

(b) The Department of Human Services shall provide meeting space and administrative and research support to the task force.

Subd. 3. **Duties.** (a) The task force must make findings and recommendations related to waiver reimagine in Minnesota, including but not limited to the following:

(1) consolidation of the existing four disability home and community-based waiver service programs into two waiver programs;

(2) budgets based on the needs of the individual that are not tied to location of services, including resources beyond those required to meet assessed needs that may be necessary for the individual to live in the least restrictive environment;

(3) criteria and processes for provider rate exceptions and individualized budget exceptions;

(4) appropriate assessments, including the MnCHOICES 2.0 assessment tool, in determining service needs and individualized budgets;

(5) covered services under each disability waiver program, including any proposed adjustments to the menu of services;

(6) service planning and authorization processes for disability waiver services;

(7) a plan of support, financial and otherwise, to live in the person's own home and in the most integrated setting as defined under Title 2 of the Americans with Disabilities Act Integration Mandate and in Minnesota's Olmstead Plan;

(8) intended and unintended outcomes of waiver reimagine; and

(9) other items related to waiver reimagine as necessary.

(b) The task force must seek input from the public, counties, persons receiving disability waiver services, families of persons receiving disability waiver services, providers, state agencies, and advocacy groups.

(c) The task force must hold public meetings to gather information to fulfill the purpose of the task force. The meetings must be accessible by remote participants.

(d) The Department of Human Services shall provide relevant data and research to the task force to facilitate the task force's work.

Subd. 4. **Compensation; expenses.** Members of the task force may receive compensation and expense reimbursement as provided in section 15.059, subdivision 3.

Subd. 5. **Report.** (a) The task force shall submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over disability waiver services no later than January 15, 2027, that describes any concerns or recommendations related to waiver reimagine as identified by the task force.

(b) The report required under Laws 2021, First Special Session chapter 7, article 13, section 75, subdivision 4, as amended by Laws 2024, chapter 108, article 1, section 28, must be presented to the task force prior to December 15, 2026.

Subd. 6. **Task force does not expire.** Notwithstanding section 15.059, subdivision 6, the task force under this section does not expire.

History: *1Sp2025 c 9 art 2 s 29*

256B.491 MS 2012 [Repealed, 2014 c 262 art 4 s 9]

256B.4911 CONSUMER-DIRECTED COMMUNITY SUPPORTS.

Subdivision 1. **Federal authority.** Consumer-directed community supports, as referenced in sections 256B.0913, subdivision 5, paragraph (a), clause (17); 256B.092, subdivision 1b, clause (4); 256B.49, subdivision 16, paragraph (c); and chapter 256S are governed, in whole, by the federally-approved waiver plans for home and community-based services.

Subd. 2. **Costs associated with physical activities.** The expenses allowed for adults under the consumer-directed community supports option must include the costs at the lowest rate available considering daily, monthly, semiannual, annual, or membership rates, including transportation, associated with physical exercise or other physical activities to maintain or improve the person's health and functioning.

Subd. 3. **Expansion and increase of budget exceptions.** (a) The commissioner of human services must provide up to 30 percent more funds for either:

(1) consumer-directed community supports participants under sections 256B.092 and 256B.49 who have a support plan which identifies the need for more services or supports under consumer-directed community supports than the amount the participants are currently receiving under the consumer-directed community supports budget methodology to:

(i) increase the amount of time a person works or otherwise improves employment opportunities;

(ii) plan a transition to, move to, or live in a setting described in section 256D.44, subdivision 5, paragraph (g), clause (1), item (iii); or

(iii) develop and implement a positive behavior support plan; or

(2) home and community-based waiver participants under sections 256B.092 and 256B.49 who are currently using licensed providers for: (i) employment supports or services during the day; or (ii) residential services, either of which cost more annually than the person would spend under a consumer-directed community supports plan for any or all of the supports needed to meet a goal identified in clause (1), item (i), (ii), or (iii).

(b) The exception under paragraph (a), clause (1), is limited to persons who can demonstrate that they will have to discontinue using consumer-directed community supports and accept other non-self-directed waiver services because their supports needed for a goal described in paragraph (a), clause (1), item (i), (ii), or (iii), cannot be met within the consumer-directed community supports budget limits.

(c) The exception under paragraph (a), clause (2), is limited to persons who can demonstrate that, upon choosing to become a consumer-directed community supports participant, the total cost of services, including the exception, will be less than the cost of current waiver services.

Subd. 4. **Budget exception for persons leaving institutions and crisis residential settings.** (a) The commissioner must establish an institutional and crisis bed consumer-directed community supports budget exception process in the home and community-based services waivers under sections 256B.092 and 256B.49. This budget exception process must be available for any individual who:

(1) is not offered available and appropriate services within 60 days since approval for discharge from the individual's current institutional setting; and

(2) requires services that are more expensive than appropriate services provided in a noninstitutional setting using the consumer-directed community supports option.

(b) Institutional settings for purposes of this exception include intermediate care facilities for persons with developmental disabilities, nursing facilities, acute care hospitals, Anoka Metro Regional Treatment Center, Minnesota Security Hospital, and crisis beds.

(c) The budget exception must be limited to no more than the amount of appropriate services provided in a noninstitutional setting as determined by the lead agency managing the individual's home and community-based services waiver. The lead agency must notify the Department of Human Services of the budget exception.

Subd. 5. **Shared services.** (a) Medical assistance payments for shared services under consumer-directed community supports are limited to this subdivision.

(b) For purposes of this subdivision, "shared services" means services provided at the same time by the same direct care worker for individuals who have entered into an agreement to share consumer-directed community support services.

(c) Shared services may include services in the personal assistance category as outlined in the consumer-directed community supports assessment summary and shared services agreement, except:

(1) services for more than three individuals provided by one worker at one time;

(2) use of more than one worker for the shared services; and

(3) a child care program licensed under chapter 142B or operated by a local school district or private school.

(d) The individuals, or as needed the individuals' representatives, must develop the plan for shared services when developing or amending the consumer-directed community supports plan, and must follow the consumer-directed community supports process for approval of the plan by the lead agency. The plan for shared services in an individual's consumer-directed community supports plan must include the intention to utilize shared services based on individuals' needs and preferences.

(e) Individuals sharing services must use the same financial management services provider.

(f) Individuals whose consumer-directed community supports assessment summaries include an intent to utilize shared services must jointly develop, with the support of the individuals' representatives as needed, a shared services agreement. This agreement must include:

(1) the names of the individuals receiving shared services;

(2) the individuals' representative, if identified in their consumer-directed community supports plans, and their duties;

(3) the names of the case managers;

(4) the financial management services provider;

(5) the shared services that must be provided;

(6) the schedule for shared services;

(7) the location where shared services must be provided;

(8) the training specific to each individual served;

(9) the training specific to providing shared services to the individuals identified in the agreement;

(10) instructions to follow all required documentation for time and services provided;

(11) a contingency plan for each individual that accounts for service provision and billing in the absence of one of the individuals in a shared services setting due to illness or other circumstances;

(12) signatures of all parties involved in the shared services; and

(13) agreement by each individual who is sharing services on the number of shared hours for services provided.

(g) Any individual or any individual's representative may withdraw from participating in a shared services agreement at any time.

(h) The lead agency for each individual must authorize the use of the shared services option based on the criteria that the shared service is appropriate to meet the needs, health, and safety of each individual for whom they provide case management or care coordination.

(i) This subdivision must not be construed to reduce the total authorized consumer-directed community supports budget for an individual.

(j) No later than September 30, 2019, the commissioner of human services must:

(1) submit an amendment to the Centers for Medicare and Medicaid Services for the home and community-based services waivers authorized under sections 256B.0913, 256B.092, and 256B.49, and chapter 256S, to allow for a shared services option under consumer-directed community supports; and

(2) with stakeholder input, develop guidance for shared services in consumer-directed community supports within the community-based services manual. Guidance must include:

(i) recommendations for negotiating payment for one-to-two and one-to-three services; and

(ii) a template of the shared services agreement.

Subd. 6. **Services provided by parents and spouses.** (a) This subdivision limits medical assistance payments under the consumer-directed community supports option for personal assistance services provided by a parent to the parent's minor child or by a participant's spouse. This subdivision applies to the consumer-directed community supports option available under all of the following:

(1) alternative care program;

(2) brain injury waiver;

(3) community alternative care waiver;

(4) community access for disability inclusion waiver;

(5) developmental disabilities waiver; and

(6) elderly waiver.

(b) For the purposes of this subdivision, "parent" means a parent, stepparent, or legal guardian of a minor.

(c) If multiple parents are providing personal assistance services to their minor child or children, each parent may provide up to 40 hours of personal assistance services in any seven-day period regardless of the number of children served. The total number of hours of medical assistance home and community-based services provided by all of the parents must not exceed 80 hours in a seven-day period regardless of the number of children served.

(d) If only one parent is providing personal assistance services to a minor child or children, the parent may provide up to 60 hours of medical assistance home and community-based services in a seven-day period regardless of the number of children served.

(e) Subject to the hour limits in paragraphs (c) and (d), a parent may provide personal assistance services to a minor child while traveling temporarily out of state if the minor child has an assessed activity of daily living dependency requiring supervision, direction, cueing, or hands-on assistance.

(f) If a participant's spouse is providing personal assistance services, the spouse may provide up to 60 hours of medical assistance home and community-based services in a seven-day period.

(g) This subdivision must not be construed to permit an increase in the total authorized consumer-directed community supports budget for an individual.

Subd. 7. **Budget procedures.** When a lead agency authorizes or reauthorizes consumer-directed community supports services for a home and community-based services waiver participant, the lead agency must provide to the waiver participant and the waiver participant's legal representative the following information in an accessible format and in a manner that meets the participant's needs:

(1) an explanation of how the participant's consumer-directed community supports services budget was calculated, including a detailed explanation of the variables used in the budget formula;

(2) a copy of the formula used to calculate the participant's consumer-directed community supports services budget; and

(3) information about the participant's right to appeal the consumer-directed community supports services budget in accordance with sections 256.045 and 256.0451.

Subd. 8. **Consumer-directed community supports policy.** Policies governing the consumer-directed community supports program must be created solely by the commissioner. Lead agencies must not create or implement any policies that are in addition to or inconsistent with policies created by the commissioner or federal or state laws. Any handbooks, procedures, or other guidance documents maintained by a lead agency do not have the force or effect of law, and must not be given deference if introduced in a state fair hearing conducted under sections 256.045 and 256.0451.

History: *1Sp2020 c 2 art 2 s 30; 2022 c 98 art 17 s 26; 2023 c 61 art 1 s 23; 2024 c 80 art 2 s 74; 2024 c 85 s 73; 2024 c 115 art 16 s 41; 2024 c 125 art 1 s 22,23; 2024 c 127 art 46 s 22,23; 2025 c 38 art 1 s 20*

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 chapter 256S and sections 256B.0913, 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) A provider shall not require or coerce any service recipient to change waiver programs or move to a different location, consistent with the informed choice and independent living policies under section 256B.4905, subdivisions 1a, 2a, 3a, 7, and 8.

(c) For staff that provide direct contact, as defined in section 245C.02, subdivision 11, for services specified in the federally approved waiver plans, providers must meet the requirements of chapter 245C and

maintain documentation of background study requests and results. This requirement also applies to consumer-directed community supports.

(d) 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. 1a. **Annual labor market reporting.** (a) As determined by the commissioner, a provider of home and community-based services for the elderly under chapter 256S and section 256B.0913, home and community-based services for people with developmental disabilities under section 256B.092, and home and community-based services for people with disabilities under section 256B.49 shall submit data to the commissioner on the following:

(1) number of direct-care staff;

(2) wages of direct-care staff;

(3) hours worked by direct-care staff;

(4) overtime wages of direct-care staff;

(5) overtime hours worked by direct-care staff;

(6) benefits paid and accrued by direct-care staff;

(7) direct-care staff retention rates;

(8) direct-care staff job vacancies;

(9) amount of travel time paid;

(10) program vacancy rates; and

(11) other related data requested by the commissioner.

(b) The commissioner may adjust reporting requirements for a self-employed direct-care staff.

(c) For the purposes of this subdivision, "direct-care staff" means employees, including self-employed individuals and individuals directly employed by a participant in a consumer-directed service delivery option, providing direct service provision to people receiving services under this section. Direct-care staff does not include executive, managerial, or administrative staff.

(d) This subdivision also applies to a provider of personal care assistance services under section 256B.0625, subdivision 19a; community first services and supports under section 256B.85; nursing services and home health services under section 256B.0625, subdivision 6a; home care nursing services under section 256B.0625, subdivision 7; or day training and habilitation services for residents of intermediate care facilities for persons with developmental disabilities under section 256B.501.

(e) This subdivision also applies to financial management services providers for participants who directly employ direct-care staff through consumer support grants under section 256.476; the personal care assistance choice program under section 256B.0659, subdivisions 18 to 20; community first services and supports under section 256B.85; and the consumer-directed community supports option available under the alternative care program, the brain injury waiver, the community alternative care waiver, the community access for

disability inclusion waiver, the developmental disabilities waiver, the elderly waiver, and the Minnesota senior health option, except financial management services providers are not required to submit the data listed in paragraph (a), clauses (7) to (11).

(f) The commissioner shall ensure that data submitted under this subdivision is not duplicative of data submitted under any other section of this chapter or any other chapter.

(g) A provider shall submit the data annually on a date specified by the commissioner. The commissioner shall give a provider at least 30 calendar days to submit the data. If a provider fails to submit the requested data by the date specified by the commissioner, the commissioner may delay medical assistance reimbursement until the requested data is submitted.

(h) Individually identifiable data submitted to the commissioner in this section are considered private data on an individual, as defined by section 13.02, subdivision 12.

(i) The commissioner shall analyze data annually for workforce assessments and how the data impact service access.

Subd. 1b. **Direct support professional annual labor market survey.** (a) The commissioner shall develop and administer a survey of direct care staff who work for organizations that provide services under the following programs:

(1) home and community-based services for seniors under chapter 256S and section 256B.0913; home and community-based services for people with developmental disabilities under section 256B.092; and home and community-based services for people with disabilities under section 256B.49;

(2) personal care assistance services under section 256B.0625, subdivision 19a; community first services and supports under section 256B.85; nursing services and home health services under section 256B.0625, subdivision 6a; and home care nursing services under section 256B.0625, subdivision 7; and

(3) financial management services for participants who directly employ direct-care staff through consumer support grants under section 256.476; the personal care assistance choice program under section 256B.0659, subdivisions 18 to 20; community first services and supports under section 256B.85; and the consumer-directed community supports option available under the alternative care program, the brain injury waiver, the community alternative care waiver, the community access for disability inclusion waiver, the developmental disabilities waiver, the elderly waiver, and the Minnesota senior health option, except financial management services providers are not required to submit the data listed in subdivision 1a, clauses (7) to (11).

(b) The survey must collect information about the individual experience of the direct-care staff and any other information necessary to assess the overall economic viability and well-being of the workforce.

(c) For purposes of this subdivision, "direct-care staff" means employees, including self-employed individuals and individuals directly employed by a participant in a consumer-directed service delivery option, providing direct service to participants under this section. Direct-care staff does not include executive, managerial, or administrative staff.

(d) Individually identifiable data submitted to the commissioner under this section are considered private data on individuals as defined by section 13.02, subdivision 12.

(e) The commissioner shall analyze data submitted under this section annually to assess the overall economic viability and well-being of the workforce and the impact of the state of the workforce on access to services.

Subd. 1c. **Annual labor market report.** The commissioner shall publish annual reports on provider and state-level labor market data, including but not limited to the data outlined in subdivisions 1a and 1b.

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.

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 3300.6000 to 3300.6070, 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 chapter 256S and sections 256B.0913, 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 chapter 256S and sections 256B.0913, 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 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. **Provider 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.

Subd. 11. **Home and community-based service billing requirements.** (a) A home and community-based service is eligible for reimbursement if:

(1) the service is provided according to a federally approved waiver plan as authorized under chapter 256S and sections 256B.0913, 256B.092, and 256B.49;

(2) the service is provided on days and times during the days and hours of operation specified on any license required under chapter 245A or 245D, if applicable; and

(3) the provider complies with subdivisions 12 to 15, if applicable.

(b) The provider must maintain documentation that, upon employment and annually thereafter, staff providing a service have attested to reviewing and understanding the following statement: "It is a federal crime to provide materially false information on service billings for medical assistance or services provided under a federally approved waiver plan as authorized under Minnesota Statutes, chapter 256S, and Minnesota Statutes, sections 256B.0913, 256B.092, and 256B.49."

(c) The department may recover payment according to section 256B.064 and Minnesota Rules, parts 9505.2160 to 9505.2245, for a service that does not satisfy this subdivision.

Subd. 12. **Home and community-based service documentation requirements.** (a) Documentation may be collected and maintained electronically or in paper form by providers and must be produced upon request by the commissioner.

(b) Documentation of a delivered service must be in English and must be legible according to the standard of a reasonable person.

(c) If the service is reimbursed at an hourly or specified minute-based rate, each documentation of the provision of a service, unless otherwise specified, must include:

(1) the date the documentation occurred;

(2) the day, month, and year when the service was provided;

(3) the start and stop times with a.m. and p.m. designations, except for case management services as defined under chapter 256S and sections 256B.0913, subdivision 7; 256B.092, subdivision 1a; and 256B.49, subdivision 13;

(4) the service name or description of the service provided; and

(5) the name, signature, and title, if any, of the provider of service. If the service is provided by multiple staff members, the provider may designate a staff member responsible for verifying services and completing the documentation required by this paragraph.

(d) If the service is reimbursed at a daily rate or does not meet the requirements in paragraph (c), each documentation of the provision of a service, unless otherwise specified, must include:

(1) the date the documentation occurred;

(2) the day, month, and year when the service was provided;

(3) the service name or description of the service provided; and

(4) the name, signature, and title, if any, of the person providing the service. If the service is provided by multiple staff, the provider may designate a staff member responsible for verifying services and completing the documentation required by this paragraph.

Subd. 13. **Waiver transportation documentation and billing requirements.** (a) A waiver transportation service must be a waiver transportation service that: (1) is not covered by medical transportation under the Medicaid state plan; and (2) is not included as a component of another waiver service.

(b) In addition to the documentation requirements in subdivision 12, a waiver transportation service provider must maintain:

(1) odometer and other records pursuant to section 256B.0625, subdivision 17b, paragraph (b), clause (3), sufficient to distinguish an individual trip with a specific vehicle and driver for a waiver transportation service that is billed directly by the mile. A common carrier as defined by Minnesota Rules, part 9505.0315, subpart 1, item B, or a publicly operated transit system provider are exempt from this clause; and

(2) documentation demonstrating that a vehicle and a driver meet the transportation waiver service provider standards and qualifications according to the federally approved waiver plan.

Subd. 14. **Equipment and supply documentation requirements.** (a) In addition to the requirements in subdivision 12, an equipment and supply services provider must for each documentation of the provision of a service include:

(1) the recipient's assessed need for the equipment or supply;

(2) the reason the equipment or supply is not covered by the Medicaid state plan;

(3) the type and brand name of the equipment or supply delivered to or purchased by the recipient, including whether the equipment or supply was rented or purchased;

(4) the quantity of the equipment or supply delivered or purchased; and

(5) the cost of the equipment or supply if the amount paid for the service depends on the cost.

(b) A provider must maintain a copy of the shipping invoice or a delivery service tracking log or other documentation showing the date of delivery that proves the equipment or supply was delivered to the recipient or a receipt if the equipment or supply was purchased by the recipient.

Subd. 15. **Adult day service documentation and billing requirements.** (a) In addition to the requirements in subdivision 12, a provider of adult day services as defined in section 245A.02, subdivision 2a, and licensed under Minnesota Rules, parts 9555.9600 to 9555.9730, must maintain documentation of:

(1) a needs assessment and current plan of care according to section 245A.143, subdivisions 4 to 7, or Minnesota Rules, part 9555.9700, for each recipient, if applicable;

(2) attendance records as specified under section 245A.14, subdivision 14, paragraph (a), including the date of attendance with the day, month, and year; and the pickup and drop-off time in hours and minutes with a.m. and p.m. designations;

(3) the monthly and quarterly program requirements in Minnesota Rules, part 9555.9710, subparts 1, items E and H; 3; 4; and 6, if applicable;

(4) the name and qualification of each registered physical therapist, registered nurse, and registered dietitian who provides services to the adult day services or nonresidential program; and

(5) the location where the service was provided. If the location is an alternate location from the usual place of service, the documentation must include the address, or a description if the address is not available, of both the origin site and destination site; the length of time at the alternate location with a.m. and p.m. designations; and a list of participants who went to the alternate location.

(b) A provider must not exceed the provider's licensed capacity. If a provider exceeds the provider's licensed capacity, the department must recover all Minnesota health care programs payments from the date the provider exceeded licensed capacity.

Subd. 16. **Rates established by the commissioner.** For homemaker services eligible for reimbursement under the developmental disabilities waiver, the brain injury waiver, the community alternative care waiver, and the community access for disability inclusion waiver, the commissioner must establish rates equal to the rates established under sections 256S.21 to 256S.215 for the corresponding homemaker services.

Subd. 17. **Billing limits.** (a) Effective January 1, 2027, or upon federal approval, whichever is later, billable unit maximums are established for the following services authorized under sections 256B.092 and 256B.49:

(1) for assistive technology authorized under section 256B.092, a maximum of $10,000 annually per recipient;

(2) for chore services, a maximum of 24 units per week per recipient, where a unit is defined as a 15-minute increment;

(3) for homemaker services, cleaning and home management may be provided for a maximum of 16 hours combined per week per recipient;

(4) for family training and counseling, a maximum of two hours per week per recipient;

(5) for independent living skills, a maximum of six hours per day per recipient; and

(6) for personal emergency response system services, a maximum of one unit per month per recipient.

(b) The limits in this subdivision do not limit a person's use of other waiver services. Billing limits under this subdivision apply only to the individual service listed and do not prohibit the recipient from accessing other services for which they are eligible on the same day, week, or month, subject to other applicable requirements.

Subd. 18. **Prohibition on room and board payments.** (a) The provider must not use medical assistance money to pay for room and board, including but not limited to rent, mortgage payments, utilities, property taxes, homeowners association fees, or any other housing-related cost, in accordance with federal home and community-based services waiver requirements under United States Code, title 42, section 1396n(c), and Code of Federal Regulations, title 42, section 441.310.

(b) A provider of home and community-based services, including but not limited to integrated community supports under section 245D.03, subdivision 1, paragraph (c), clause (8), must not:

(1) use, allocate, or apply any payment for home and community-based services to cover, subsidize, discount, or otherwise contribute to any room and board expenses for a person receiving services;

(2) apply agency operating margins, reserves, or profits derived from home and community-based services to pay for rent or pay other housing costs for persons receiving services; or

(3) enter into any financial arrangement, discount, concession, or reimbursement structure that has the effect of using medical assistance service revenue to offset the housing costs of a person receiving services.

(c) Nothing in this subdivision prohibits a provider from charging a person for room and board in accordance with chapter 504B or applicable housing support laws, provided the charge is independent of medical assistance payments and complies with all federal home and community-based services setting requirements, including but not limited to tenancy protections under Code of Federal Regulations, title 42, section 441.301(c)(4)(vi)(A).

(d) The commissioner may pursue corrective action, payment recovery, sanctions under section 256B.064, and licensing action under chapter 245A or 245D for a violation of this subdivision.

(e) Notwithstanding paragraphs (a) and (b), payment for room and board is permitted when explicitly included as part of a service authorized in a federally approved home and community-based services waiver under United States Code, title 42, section 1396n(c).

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; 2019 c 54 art 1 s 33; art 2 s 35-37; 1Sp2019 c 9 art 2 s 122-126; art 5 s 54; 2021 c 30 art 13 s 56; 2022 c 55 art 1 s 134,135; 2023 c 25 s 143; 2023 c 61 art 1 s 24-26; 2024 c 125 art 1 s 24; 2024 c 127 art 46 s 24; 1Sp2025 c 3 art 17 s 10; 2026 c 121 art 9 s 21,22*

256B.4913 Subdivision 1. MS 2012 [Repealed, 2013 c 108 art 13 s 14]

Subd. 2. MS 2012 [Repealed, 2013 c 108 art 13 s 14]

Subd. 3. MS 2012 [Repealed, 2013 c 108 art 13 s 14]

Subd. 4. MS 2012 [Repealed, 2013 c 108 art 13 s 14]

Subd. 4a. MS 2018 [Repealed, 1Sp2019 c 9 art 5 s 94]

Subd. 5. MS 2018 [Repealed, 1Sp2019 c 9 art 5 s 94]

Subd. 6. MS 2018 [Repealed, 1Sp2019 c 9 art 5 s 94]

Subd. 7. MS 2018 [Repealed, 1Sp2019 c 9 art 5 s 94]

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) "Comparable occupations" means the occupations, excluding direct care staff, as represented by the Bureau of Labor Statistics standard occupational classification codes that have the same classification for:

(1) typical education needed for entry;

(2) work experience in a related occupation; and

(3) typical on-the-job training competency as the most predominant classification for direct care staff.

(d) "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.

(e) "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.

(f) "Direct care staff" means employees providing direct service to people receiving services under this section. Direct care staff excludes executive, managerial, and administrative staff.

(g) "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.

(h) "Individual direct staffing hours" means the time spent as a one-to-one interaction specific to an individual recipient by staff 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 support plan under section 245D.02, subdivision 4b; any support plan addendum under section 245D.02, subdivision 4c; and an assessment tool. Provider observation of an individual's needs must also be considered.

(i) "Lead agency" means a county, partnership of counties, or Tribal agency charged with administering waivered services under sections 256B.092 and 256B.49.

(j) "Payment or rate" means reimbursement to an eligible provider for services provided to a qualified individual based on an approved service authorization.

(k) "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.

(l) "Recipient" means a person receiving home and community-based services funded under any of the disability waivers.

(m) "Shared direct staffing hours" 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 support plan under section 245D.02, subdivision 4b; any 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.

(n) "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.

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 services;

(3) adult day services bath;

(4) community residential services;

(5) customized living;

(6) day support services;

(7) employment development services;

(8) employment exploration services;

(9) employment support services;

(10) family residential services;

(11) individualized home supports;

(12) individualized home supports with family training;

(13) individualized home supports with training;

(14) integrated community supports;

(15) life sharing;

(16) effective until the effective date of clauses (17) and (18), night supervision;

(17) effective January 1, 2026, or upon federal approval, whichever is later, awake night supervision;

(18) effective January 1, 2026, or upon federal approval, whichever is later, asleep night supervision;

(19) positive support services;

(20) prevocational services;

(21) residential support services;

(22) transportation services;

(23) effective October 1, 2027, or upon federal approval, whichever is later, integrated community supports access services; and

(24) other services as approved by the federal government in the state home and community-based services waiver plan.

[See Note.]

Subd. 4. **Data collection for rate determination.** (a) Rates for applicable home and community-based waivered services, including customized rates under subdivision 12, are set by the rates management system.

(b) Data and information in the rates management system must be used to calculate an individual's rate.

(c) Service providers, with information from the support plan and oversight by lead agencies, shall provide values and information needed to calculate an individual's rate in the rates management system. Lead agencies must use forms provided by the commissioner to collect this information. 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.

(d) Updates to individual data must include:

(1) data for each individual that is updated annually when renewing service plans; and

(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.

(e) 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 to 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 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 (h), (n), and (o); 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 (o), and meeting or exceeding the licensing standards for staffing required under section 245D.31.

Subd. 5. **Base wage index; establishment and updates.** (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 calculating the 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 Occupational Handbook must be used.

(b) The commissioner shall establish the base wage index in subdivision 5a, publish these updated values, and load them into the rate management system on January 1, 2024, based on wage data by SOC from the Bureau of Labor Statistics published in March 2022.

Subd. 5a. **Base wage index; calculations.** The base wage index must be calculated as follows:

(1) for supervisory staff, 100 percent of the median wage for community and social services specialist (SOC code 21-1099), with the exception of the supervisor of positive supports professional, positive supports analyst, and positive supports specialist, which is 100 percent of the median wage for clinical counseling and school psychologist (SOC code 19-3031);

(2) for registered nurse staff, 100 percent of the median wage for registered nurses (SOC code 29-1141);

(3) for licensed practical nurse staff, 100 percent of the median wage for licensed practical nurses (SOC code 29-2061);

(4) for residential asleep-overnight staff, the minimum wage in Minnesota for large employers;

(5) for residential direct care staff, the sum of:

(i) 15 percent of the subtotal of 50 percent of the median wage for home health and personal care aide (SOC code 31-1120); 30 percent of the median wage for nursing assistant (SOC code 31-1131); 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 40 percent of the median wage for home health and personal care aide (SOC code 31-1120); 20 percent of the median wage for nursing assistant (SOC code 31-1131); 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);

(6) for adult day services staff, 70 percent of the median wage for nursing assistant (SOC code 31-1131); and 30 percent of the median wage for home health and personal care aide (SOC code 31-1120);

(7) for day support services staff and prevocational services staff, 20 percent of the median wage for nursing assistant (SOC code 31-1131); 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 positive supports analyst staff, 100 percent of the median wage for substance abuse, behavioral disorder, and mental health counselor (SOC code 21-1018);

(9) for positive supports professional staff, 100 percent of the median wage for clinical counseling and school psychologist (SOC code 19-3031);

(10) for positive supports specialist staff, 100 percent of the median wage for psychiatric technicians (SOC code 29-2053);

(11) for individualized home supports with family training staff, 20 percent of the median wage for nursing aide (SOC code 31-1131); 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);

(12) for individualized home supports with training services 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);

(13) for employment support services staff, 50 percent of the median wage for rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

(14) for employment exploration services staff, 50 percent of the median wage for education, guidance, school, and vocational counselor (SOC code 21-1012); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

(15) for employment development services staff, 50 percent of the median wage for education, guidance, school, and vocational counselors (SOC code 21-1012); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

(16) for individualized home support without training staff, 50 percent of the median wage for home health and personal care aide (SOC code 31-1120); and 50 percent of the median wage for nursing assistant (SOC code 31-1131);

(17) effective until the effective date of clauses (18) and (19), for night supervision staff, 40 percent of the median wage for home health and personal care aide (SOC code 31-1120); 20 percent of the median wage for nursing assistant (SOC code 31-1131); 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);

(18) effective January 1, 2026, or upon federal approval, whichever is later, for awake night supervision staff, 40 percent of the median wage for home health and personal care aide (SOC code 31-1120); 20 percent of the median wage for nursing assistant (SOC code 31-1131); 20 of percent the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aid (SOC code 21-1093);

(19) effective January 1, 2026, or upon federal approval, whichever is later, for asleep night supervision staff, the minimum wage in Minnesota for large employers; and

(20) effective October 1, 2027, or upon federal approval, whichever is later, for integrated community support staff, the sum of:

(i) 15 percent of the subtotal of 50 percent of the median wage for home health and personal care aide (SOC code 31-1120); 30 percent of the median wage for nursing assistant (SOC code 31-1131); 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 40 percent of the median wage for home health and personal care aide (SOC code 31-1120); 20 percent of the median wage for nursing assistant (SOC code 31-1131); 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).

[See Note.]

Subd. 5b. **Standard component value adjustments.** The commissioner shall update the base wage index under subdivision 5a; client and programming support, transportation, and program facility cost component values as required in subdivisions 6 to 9; and the rates identified in subdivision 19 for changes in the Consumer Price Index. If the result of this update exceeds eight percent, the commissioner shall

implement a change to the base wage index, component values, and rates under subdivision 19 of eight percent. If the result of this update is less than eight percent, the commissioner shall implement the full value of the change. The commissioner shall adjust these values higher or lower, publish these updated values, and load them into the rate management system on January 1, 2026, and every two years thereafter, by the percentage change in the CPI-U from the date of the previous update to the data available 24 months and one day prior to the scheduled update.

[See Note.]

Subd. 5c. **Removal of after-framework adjustments.** Any rate adjustments applied to the service rates calculated under this section outside of the cost components and rate methodology specified in this section shall be removed from rate calculations upon implementation of the updates under subdivisions 5 and 5b.

Subd. 5d. **Unavailable data for updates and adjustments.** If Bureau of Labor Statistics occupational codes or Consumer Price Index items specified in subdivision 5 or 5b are unavailable in the future, the commissioner shall recommend to the legislature codes or items to update and replace.

Subd. 5e. MS 2024 [Expired]

Subd. 6. **Residential support services; generally.** (a) For purposes of this section, residential support services includes 24-hour customized living services, community residential services, customized living services, and integrated community supports.

(b) Effective October 1, 2027, or upon federal approval, whichever is later, for purposes of this section, residential support services includes 24-hour customized living services, community residential services, customized living services, and integrated community supports access services.

(c) A unit of service for residential support services 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. The number of days authorized for all individuals enrolling in residential support services must include every day that services start and end.

(d) When the available shared staffing hours in a residential setting are insufficient to meet the needs of an individual who enrolled in residential support services after January 1, 2014, then individual staffing hours shall be used.

[See Note.]

Subd. 6a. **Community residential services; component values and calculation of payment rates.** (a) Component values for community residential services are:

(1) competitive workforce factor: 6.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) general administrative support ratio: 13.25 percent;

(6) program-related expense ratio: 1.3 percent; and

(7) absence and utilization factor ratio: 3.9 percent.

(b) Payments for community residential services must be calculated as follows:

(1) determine the number of shared direct staffing and individual direct staffing hours to meet a recipient's needs provided on site or through monitoring technology;

(2) determine the appropriate hourly staff wage rates derived by the commissioner as provided in subdivisions 5 and 5a;

(3) except for subdivision 5a, clauses (1) to (4), multiply the result of clause (2) by the product of one plus the competitive workforce factor;

(4) 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 (3);

(5) multiply the number of shared direct staffing and individual direct staffing hours provided on site or through monitoring technology and nursing hours by the appropriate staff wages;

(6) multiply the number of shared direct staffing and individual direct staffing hours provided on site or through monitoring technology and nursing hours by the product of the supervision span of control ratio and the appropriate supervisory staff wage in subdivision 5a, clause (1);

(7) combine the results of clauses (5) and (6), excluding any shared direct staffing and individual direct staffing hours provided through monitoring technology, and multiply the result by one plus the employee vacation, sick, and training allowance ratio. This is defined as the direct staffing cost;

(8) for employee-related expenses, multiply the direct staffing cost, excluding any shared direct staffing and individual hours provided through monitoring technology, by one plus the employee-related cost ratio;

(9) for client programming and supports, add $2,260.21 divided by 365. The commissioner shall update the amount in this clause as specified in subdivision 5b;

(10) for transportation, if provided, add $1,742.62 divided by 365, or $3,111.81 divided by 365 if customized for adapted transport, based on the resident with the highest assessed need. The commissioner shall update the amounts in this clause as specified in subdivision 5b;

(11) subtotal clauses (8) to (10) and the direct staffing cost of any shared direct staffing and individual direct staffing hours provided through monitoring technology that was excluded in clause (8);

(12) sum the standard general administrative support ratio, the program-related expense ratio, and the absence and utilization factor ratio;

(13) divide the result of clause (11) by one minus the result of clause (12). This is the total payment amount; 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.

(c) Effective July 1, 2027, the commissioner must establish the following acuity-based community residential service tool input limits on total individual hours entered, based on the case mix rates determined under this section:

(1) zero individual hours per day for people assessed for case mixes A, C, and L;

(2) no more than six individual hours per day for people assessed for case mixes B, D, and F;

(3) no more than 16 individual hours per day for people assessed for case mixes E, G, I, J, and K; and

(4) no more than 24 individual hours per day for people assessed for case mix H or residing in a community residential setting licensed for one person regardless of case mix level.

(d) The commissioner must provide an exception process under subdivision 14 to the limits in paragraph (c) for individuals with extraordinary needs who might otherwise end up in institutional settings without additional authorized individual hour inputs.

[See Note.]

Subd. 6b. **Family residential services; component values and calculation of payment rates.** (a) Component values for family residential services are:

(1) competitive workforce factor: 6.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) general administrative support ratio: 3.3 percent;

(6) program-related expense ratio: 1.3 percent; and

(7) absence factor: 1.7 percent.

(b) Payments for family residential services must be calculated as follows:

(1) determine the number of shared direct staffing and individual direct staffing hours to meet a recipient's needs provided on site or through monitoring technology;

(2) determine the appropriate hourly staff wage rates derived by the commissioner as provided in subdivisions 5 and 5a;

(3) except for subdivision 5a, clauses (1) to (4), multiply the result of clause (2) by the product of one plus the competitive workforce factor;

(4) 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 (3);

(5) multiply the number of shared direct staffing and individual direct staffing hours provided on site or through monitoring technology and nursing hours by the appropriate staff wages;

(6) multiply the number of shared direct staffing and individual direct staffing hours provided on site or through monitoring technology and nursing hours by the product of the supervisory span of control ratio and the appropriate supervisory staff wage in subdivision 5a, clause (1);

(7) combine the results of clauses (5) and (6), excluding any shared direct staffing and individual direct staffing hours provided through monitoring technology, and multiply the result by one plus the employee vacation, sick, and training allowance ratio. This is defined as the direct staffing cost;

(8) for employee-related expenses, multiply the direct staffing cost, excluding any shared and individual direct staffing hours provided through monitoring technology, by one plus the employee-related cost ratio;

(9) for client programming and supports, add $2,260.21 divided by 365. The commissioner shall update the amount in this clause as specified in subdivision 5b;

(10) for transportation, if provided, add $1,742.62 divided by 365, or $3,111.81 divided by 365 if customized for adapted transport, based on the resident with the highest assessed need. The commissioner shall update the amounts in this clause as specified in subdivision 5b;

(11) subtotal clauses (8) to (10) and the direct staffing cost of any shared direct staffing and individual direct staffing hours provided through monitoring technology that was excluded in clause (8);

(12) sum the standard general administrative support ratio, the program-related expense ratio, and the absence and utilization factor ratio;

(13) divide the result of clause (11) by one minus the result of clause (12). This is the total payment rate; 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.

[See Note.]

Subd. 6c. **Integrated community supports; component values and calculation of payment rates.** (a) Component values for integrated community supports are:

(1) competitive workforce factor: 6.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) general administrative support ratio: 13.25 percent;

(6) program-related expense ratio: 1.3 percent; and

(7) absence and utilization factor ratio: 3.9 percent.

(b) Payments for integrated community supports must be calculated as follows:

(1) determine the number of shared direct staffing and individual direct staffing hours to meet a recipient's needs. The base shared direct staffing hours must be eight hours divided by the approved capacity of the integrated community support setting, and the individual direct staffing hours must be the average number of direct support hours provided directly to the service recipient;

(2) determine the appropriate hourly staff wage rates derived by the commissioner as provided in subdivisions 5 and 5a;

(3) except for subdivision 5a, clauses (1) to (4), multiply the result of clause (2) by the product of one plus the competitive workforce factor;

(4) 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 (3);

(5) multiply the number of shared direct staffing and individual direct staffing hours in clause (1) by the appropriate staff wages;

(6) multiply the number of shared direct staffing and individual direct staffing hours in clause (1) by the product of the supervisory span of control ratio and the appropriate supervisory staff wage in subdivision 5a, clause (1);

(7) combine the results of clauses (5) and (6) and multiply the result by one plus the employee vacation, sick, and training allowance ratio. This is defined as the direct staffing cost;

(8) for employee-related expenses, multiply the direct staffing cost by one plus the employee-related cost ratio;

(9) for client programming and supports, add $2,260.21 divided by 365. The commissioner shall update the amount in this clause as specified in subdivision 5b;

(10) add the results of clauses (8) and (9);

(11) add the standard general administrative support ratio, 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; and

(13) adjust the result of clause (12) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

(c) The commissioner must establish maximum allowable in-person and remote service hours used in the rate methodology for integrated community supports based on the recipient's case mix classification. Effective January 1, 2027, the total number of service hours entered into the rate framework must not exceed the following limits:

(1) for case mix classifications A, C, and L, a maximum of two hours per day;

(2) for case mix classifications B, D, and F, a maximum of four hours per day;

(3) for case mix classifications E, G, I, J, and K, a maximum of six hours per day; and

(4) for case mix classification H, a maximum of eight hours per day.

(d) The daily limit in paragraph (c) does not limit a person's use of other disability waiver services that may be provided on the same day in alignment with the federally approved waiver. Nothing in paragraph (c) prohibits approval of a rate exception for individuals with exceptional or complex needs.

(e) This subdivision expires upon the effective date of subdivisions 6e and 8a.

[See Note.]

Subd. 6d. **Payment for customized living.** (a) The payment methodology for customized living and 24-hour customized living must be the customized living tool. The commissioner shall revise the customized living tool to reflect the services and activities unique to disability-related recipient needs and adjust for regional differences in the cost of providing services.

(b) The rate adjustments described in section 256S.205 do not apply to rates paid under this section.

(c) Customized living and 24-hour customized living rates determined under this section shall not include more than 24 hours of support in a daily unit.

(d) The commissioner shall establish the following acuity-based customized living tool input limits, based on case mix, for customized living and 24-hour customized living rates determined under this section:

(1) no more than two hours of mental health management per day for people assessed for case mixes A, D, and G;

(2) no more than four hours of activities of daily living assistance per day for people assessed for case mix B; and

(3) no more than six hours of activities of daily living assistance per day for people assessed for case mix D.

(e) Effective January 1, 2027, or upon federal approval, whichever is later, customized living monthly service rate limits must equal the monthly service rate limits determined under section 256S.202, subdivisions 1 and 2, multiplied by 126.36 percent.

Subd. 6e. **Integrated community supports access services; component values and calculation of payment rates.** (a) This subdivision is effective October 1, 2027, or upon federal approval, whichever is later.

(b) Component values for integrated community supports access services are:

(1) competitive workforce factor: 6.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) general administrative support ratio: 13.25 percent;

(6) program-related expense ratio: 1.3 percent; and

(7) absence and utilization factor ratio: 3.9 percent.

(c) Payments for integrated community supports access services must be calculated as follows:

(1) the base shared direct staffing hours must be eight hours divided by the approved capacity of integrated community support setting;

(2) determine the appropriate hourly staff wage rates derived by the commissioner as provided in subdivisions 5 and 5a;

(3) except for subdivision 5a, clauses (1) to (4), multiply the result of clause (2) by the product of one plus the competitive workforce factor;

(4) 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 (3);

(5) multiply the number of shared direct staffing hours in clause (1) by the appropriate staff wages;

(6) multiply the number of shared direct staffing hours in clause (1) by the product of the supervisory span of control ratio and the appropriate supervisory staff wage in subdivision 5a, clause (1);

(7) combine the results of clauses (5) and (6) and multiply the result by one plus the employee vacation, sick, and training allowance ratio. This is defined as the direct staffing cost;

(8) for employee-related expenses, multiply the direct staffing cost by one plus the employee-related cost ratio;

(9) for client programming and supports, add $2,260.21 divided by 365. The commissioner shall update the amount in this clause as specified in subdivision 5b;

(10) add the results of clauses (8) and (9);

(11) add the standard general administrative support ratio, 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; and

(13) adjust the result of clause (12) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing residential services.

Subd. 7. **Day programs; generally.** (a) For the purposes of this section, day programs include adult day services, day support services, and prevocational services.

(b) The staffing ratios for the units of service provided by a day program to a recipient in a typical week must be averaged to determine an individual's staffing ratio.

(c) The commissioner, in consultation with service providers, shall develop a uniform staffing ratio worksheet to be used by day programs to determine staffing ratios for day programs.

Subd. 7a. **Adult day services; component values and calculation of payment rates.** (a) Component values for adult day services are:

(1) competitive workforce factor: 6.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) program plan support ratio: 5.6 percent;

(6) client programming and support ratio: 7.4 percent, updated as specified in subdivision 5b;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 1.8 percent; and

(9) absence and utilization factor ratio: 9.4 percent.

(b) A unit of service for adult day services is either a day or 15 minutes. A day unit of service is six or more hours of time spent providing direct service.

(c) Payments for adult day services must be calculated as follows:

(1) determine the number of units of service and the staffing ratio to meet a recipient's needs;

(2) determine the appropriate hourly staff wage rates derived by the commissioner as provided in subdivisions 5 and 5a;

(3) except for subdivision 5a, clauses (1) to (4), multiply the result of clause (2) by the product of one plus the competitive workforce factor;

(4) 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 (3);

(5) multiply the number of day program direct staffing hours and nursing hours by the appropriate staff wage;

(6) multiply the number of day program direct staffing hours by the product of the supervisory span of control ratio and the appropriate supervisory staff wage in subdivision 5a, clause (1);

(7) combine the results of clauses (5) and (6), and multiply the result by one plus the employee vacation, sick, and training allowance ratio. This is defined as the direct staffing rate;

(8) for program plan support, multiply the result of clause (7) by one plus the program plan support ratio;

(9) for employee-related expenses, multiply the result of clause (8) by one plus the employee-related cost ratio;

(10) for client programming and supports, multiply the result of clause (9) by one plus the client programming and support ratio;

(11) for program facility costs, add $19.30 per week with consideration of staffing ratios to meet individual needs, updated as specified in subdivision 5b;

(12) for adult day bath services, add $7.01 per 15 minute unit;

(13) this is the subtotal rate;

(14) sum the standard general administrative rate support ratio, the program-related expense ratio, and the absence and utilization factor ratio;

(15) divide the result of clause (13) by one minus the result of clause (14). This is the total payment amount; and

(16) adjust the result of clause (15) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

[See Note.]

Subd. 7b. **Day support services; component values and calculation of payment rates.** (a) Component values for day support services are:

(1) competitive workforce factor: 6.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) program plan support ratio: 5.6 percent;

(6) client programming and support ratio: 10.37 percent, updated as specified in subdivision 5b;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 1.8 percent; and

(9) absence and utilization factor ratio: 9.4 percent.

(b) A unit of service for day support services is 15 minutes.

(c) Payments for day support services must be calculated as follows:

(1) determine the number of units of service and the staffing ratio to meet a recipient's needs;

(2) determine the appropriate hourly staff wage rates derived by the commissioner as provided in subdivisions 5 and 5a;

(3) except for subdivision 5a, clauses (1) to (4), multiply the result of clause (2) by the product of one plus the competitive workforce factor;

(4) 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 (3);

(5) multiply the number of day program direct staffing hours and nursing hours by the appropriate staff wage;

(6) multiply the number of day program direct staffing hours by the product of the supervisory span of control ratio and the appropriate supervisory staff wage in subdivision 5a, clause (1);

(7) combine the results of clauses (5) and (6), and multiply the result by one plus the employee vacation, sick, and training allowance ratio. This is defined as the direct staffing rate;

(8) for program plan support, multiply the result of clause (7) by one plus the program plan support ratio;

(9) for employee-related expenses, multiply the result of clause (8) by one plus the employee-related cost ratio;

(10) for client programming and supports, multiply the result of clause (9) by one plus the client programming and support ratio;

(11) for program facility costs, add $19.30 per week with consideration of staffing ratios to meet individual needs, updated as specified in subdivision 5b;

(12) this is the subtotal rate;

(13) sum the standard general administrative rate support ratio, 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; and

(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.

(d) Effective January 1, 2027, or upon federal approval, whichever is later, the billing limit for day support services is equal to a maximum of eight hours per day per recipient.

[See Note.]

Subd. 7c. **Prevocational services; component values and calculation of payment rates.** (a) Component values for prevocational services are:

(1) competitive workforce factor: 6.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) program plan support ratio: 5.6 percent;

(6) client programming and support ratio: 10.37 percent, updated as specified in subdivision 5b;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 1.8 percent; and

(9) absence and utilization factor ratio: 9.4 percent.

(b) A unit of service for prevocational services is either a day or 15 minutes. A day unit of service is six or more hours of time spent providing direct service.

(c) Payments for prevocational services must be calculated as follows:

(1) determine the number of units of service and the staffing ratio to meet a recipient's needs;

(2) determine the appropriate hourly staff wage rates derived by the commissioner as provided in subdivisions 5 and 5a;

(3) except for subdivision 5a, clauses (1) to (4), multiply the result of clause (2) by the product of one plus the competitive workforce factor;

(4) 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 (3);

(5) multiply the number of day program direct staffing hours and nursing hours by the appropriate staff wage;

(6) multiply the number of day program direct staffing hours by the product of the supervisory span of control ratio and the appropriate supervisory staff wage in subdivision 5a, clause (1);

(7) combine the results of clauses (5) and (6), and multiply the result by one plus the employee vacation, sick, and training allowance ratio. This is defined as the direct staffing rate;

(8) for program plan support, multiply the result of clause (7) by one plus the program plan support ratio;

(9) for employee-related expenses, multiply the result of clause (8) by one plus the employee-related cost ratio;

(10) for client programming and supports, multiply the result of clause (9) by one plus the client programming and support ratio;

(11) for program facility costs, add $19.30 per week with consideration of staffing ratios to meet individual needs, updated as specified in subdivision 5b;

(12) this is the subtotal rate;

(13) sum the standard general administrative rate support ratio, 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; and

(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.

[See Note.]

Subd. 8. **Unit-based services with programming; component values and calculation of payment rates.** (a) For the purpose of this section, unit-based services with programming include employment exploration services, employment development services, employment support services, individualized home supports with family training, individualized home supports with training, and positive support services provided to an individual outside of any service plan for a day program or residential support service.

(b) Component values for unit-based services with programming are:

(1) competitive workforce factor: 6.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) program plan support ratio: 15.5 percent;

(6) client programming and support ratio: 4.7 percent, updated as specified in subdivision 5b;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 6.1 percent; and

(9) absence and utilization factor ratio: 3.9 percent.

(c) A unit of service for unit-based services with programming is 15 minutes.

(d) Payments for unit-based services with programming must be calculated as follows, unless the services are reimbursed separately as part of a residential support services or day program payment rate:

(1) determine the number of units of service to meet a recipient's needs;

(2) determine the appropriate hourly staff wage rates derived by the commissioner as provided in subdivisions 5 and 5a;

(3) except for subdivision 5a, clauses (1) to (4), multiply the result of clause (2) by the product of one plus the competitive workforce factor;

(4) 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 (3);

(5) multiply the number of direct staffing hours by the appropriate staff wage;

(6) multiply the number of direct staffing hours by the product of the supervisory span of control ratio and the appropriate supervisory staff wage in subdivision 5a, clause (1);

(7) combine the results of clauses (5) and (6), and multiply the result by one plus the employee vacation, sick, and training allowance ratio. This is defined as the direct staffing rate;

(8) for program plan support, multiply the result of clause (7) by one plus the program plan support ratio;

(9) for employee-related expenses, multiply the result of clause (8) by one plus the employee-related cost ratio;

(10) for client programming and supports, multiply the result of clause (9) by one plus the client programming and support ratio;

(11) this is the subtotal rate;

(12) sum the standard general administrative support ratio, the program-related expense ratio, and the absence and utilization factor ratio;

(13) divide the result of clause (11) by one minus the result of clause (12). This is the total payment amount;

(14) for services provided in a shared manner, divide the total payment in clause (13) as follows:

(i) for employment exploration services, divide by the number of service recipients, not to exceed five;

(ii) for employment support services, divide by the number of service recipients, not to exceed six;

(iii) for individualized home supports with training and individualized home supports with family training, divide by the number of service recipients, not to exceed three; and

(iv) for night supervision, divide by the number of service recipients, not to exceed two; and

(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.

(e) Effective January 1, 2026, or upon federal approval, whichever is later, a provider must not bill more than three consecutive hours and not more than six total hours per day for individualized home supports with training and individualized home supports with family training. This daily limit does not limit a person's use of other disability waiver services, including individualized home supports, which may be provided on

the same day by the same provider providing individualized home supports with training or individualized home supports with family training. This paragraph expires upon the effective date of paragraph (f).

(f) Effective January 1, 2027, or upon federal approval, whichever is later, a provider must not bill more than:

(1) for individualized home supports with training, a monthly service limit of 182.5 hours; and

(2) for individualized home supports with family training, not more than six total hours per day.

(g) The limits in paragraph (f), clauses (1) and (2), do not limit a person's use of other disability waiver services, including individualized home supports, which may be provided on the same day by the same provider providing individualized home supports with training or individualized home supports with family training.

[See Note.]

Subd. 8a. **Integrated community supports unit-based services with programming; component values and calculation of payment rates.** (a) This subdivision is effective October 1, 2027, or upon federal approval, whichever is later.

(b) Component values for integrated community supports unit-based services with programming are:

(1) competitive workforce factor: 6.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) program plan support ratio: 11.25 percent;

(6) client programming and support ratio: 3.5 percent, updated as specified in subdivision 5b;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 1.3 percent; and

(9) absence and utilization factor ratio: 3.9 percent.

(c) A unit of integrated community supports unit-based services with programming is 15 minutes.

(d) Payments for integrated community supports unit-based services must be calculated as follows:

(1) determine the number of units of service to meet a recipient's needs;

(2) determine the appropriate hourly staff wage rates derived by the commissioner as provided in subdivisions 5 and 5a;

(3) except for subdivision 5a, clauses (1) to (4), multiply the result of clause (2) by the product of one plus the competitive workforce factor;

(4) 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 (3);

(5) multiply the number of direct staffing hours by the appropriate staff wage;

(6) multiply the number of direct staffing hours by the product of the supervisory span of control ratio and the appropriate supervisory staff wage in subdivision 5a, clause (1);

(7) combine the results of clauses (5) and (6), and multiply the result by one plus the employee vacation, sick, and training allowance ratio. This is defined as the direct staffing rate;

(8) for program plan support, multiply the result of clause (7) by one plus the program plan support ratio;

(9) for employee-related expenses, multiply the result of clause (8) by one plus the employee-related cost ratio;

(10) for client programming and supports, multiply the result of clause (9) by one plus the client programming and support ratio;

(11) this is the subtotal rate;

(12) sum the standard general administrative support ratio, the program-related expense ratio, and the absence and utilization factor ratio;

(13) divide the result of clause (11) by one minus the result of clause (12). This is the total payment amount; 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 residential services.

(e) The commissioner must establish maximum allowable in-person and remote service hours used in the rate methodology for integrated community supports based on the recipient's case mix classification. The total number of service hours entered into the rate framework must not exceed the following limits:

(1) for case mix classifications A, C, and L, a maximum of two hours per day;

(2) for case mix classifications B, D, and F, a maximum of four hours per day;

(3) for case mix classifications E, G, I, J, and K, a maximum of six hours per day; and

(4) for case mix classification H, a maximum of eight hours per day.

(f) The daily limit in paragraph (e) does not limit a person's use of other disability waiver services that may be provided on the same day in alignment with the federally approved waiver. Nothing in paragraph (e) prohibits approval of a rate exception for individuals with exceptional or complex needs.

Subd. 9. **Unit-based services without programming; component values and calculation of payment rates.** (a) For the purposes of this section, unit-based services without programming include individualized home supports without training and night supervision provided to an individual outside of any service plan for a day program or residential support service. Unit-based services without programming do not include respite. This paragraph expires upon the effective date of paragraph (b).

(b) Effective January 1, 2026, or upon federal approval, whichever is later, for the purposes of this section, unit-based services without programming include individualized home supports without training, awake night supervision, and asleep night supervision provided to an individual outside of any service plan for a day program or residential support service.

(c) Component values for unit-based services without programming are:

(1) competitive workforce factor: 6.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) program plan support ratio: 7.0 percent;

(6) client programming and support ratio: 2.3 percent, updated as specified in subdivision 5b;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 2.9 percent; and

(9) absence and utilization factor ratio: 3.9 percent.

(d) A unit of service for unit-based services without programming is 15 minutes.

(e) Payments for unit-based services without programming must be calculated as follows unless the services are reimbursed separately as part of a residential support services or day program payment rate:

(1) determine the number of units of service to meet a recipient's needs;

(2) determine the appropriate hourly staff wage rates derived by the commissioner as provided in subdivisions 5 and 5a;

(3) except for subdivision 5a, clauses (1) to (4), multiply the result of clause (2) by the product of one plus the competitive workforce factor;

(4) 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 (3);

(5) multiply the number of direct staffing hours by the appropriate staff wage;

(6) multiply the number of direct staffing hours by the product of the supervisory span of control ratio and the appropriate supervisory staff wage in subdivision 5a, clause (1);

(7) combine the results of clauses (5) and (6), and multiply the result by one plus the employee vacation, sick, and training allowance ratio. This is defined as the direct staffing rate;

(8) for program plan support, multiply the result of clause (7) by one plus the program plan support ratio;

(9) for employee-related expenses, multiply the result of clause (8) by one plus the employee-related cost ratio;

(10) for client programming and supports, multiply the result of clause (9) by one plus the client programming and support ratio;

(11) this is the subtotal rate;

(12) sum the standard general administrative support ratio, the program-related expense ratio, and the absence and utilization factor ratio;

(13) divide the result of clause (11) by one minus the result of clause (12). This is the total payment amount;

(14) for individualized home supports without training provided in a shared manner, divide the total payment amount in clause (13) by the number of service recipients, not to exceed three; and

(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.

(f) Effective January 1, 2027, or upon federal approval, whichever is later, the billing limit for awake night supervision and asleep night supervision is equal to a maximum of ten hours per day per recipient, of which no more than eight hours per day may be asleep night supervision.

[See Note.]

Subd. 9a. **Respite services; component values and calculation of payment rates.** (a) For the purposes of this section, respite services include respite services provided to an individual outside of any service plan for a day program or residential support service.

(b) Component values for respite services are:

(1) competitive workforce factor: 4.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) general administrative support ratio: 13.25 percent;

(6) program-related expense ratio: 2.9 percent; and

(7) absence and utilization factor ratio: 3.9 percent.

(c) A unit of service for respite services is 15 minutes.

(d) Payments for respite services must be calculated as follows unless the service is reimbursed separately as part of a residential support services or day program payment rate:

(1) determine the number of units of service to meet an individual's needs;

(2) determine the appropriate hourly staff wage rates derived by the commissioner as provided in subdivisions 5 and 5a;

(3) except for subdivision 5a, clauses (1) to (4), multiply the result of clause (2) by the product of one plus the competitive workforce factor;

(4) 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 (3);

(5) multiply the number of direct staffing hours by the appropriate staff wage;

(6) multiply the number of direct staffing hours by the product of the supervisory span of control ratio and the appropriate supervisory staff wage in subdivision 5a, clause (1);

(7) combine the results of clauses (5) and (6), and multiply the result by one plus the employee vacation, sick, and training allowance ratio. This is defined as the direct staffing rate;

(8) for employee-related expenses, multiply the result of clause (7) by one plus the employee-related cost ratio;

(9) this is the subtotal rate;

(10) sum the standard general administrative support ratio, the program-related expense ratio, and the absence and utilization factor ratio;

(11) divide the result of clause (9) by one minus the result of clause (10). This is the total payment amount;

(12) for respite services provided in a shared manner, divide the total payment amount in clause (11) by the number of service recipients, not to exceed three; and

(13) adjust the result of clause (12) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

(e) Effective January 1, 2027, or upon federal approval, whichever is later, the billing limit for in-home respite services is equal to a maximum of 30 consecutive days per respite occurrence.

[See Note.]

Subd. 10. **Evaluation of information and data.** (a) The commissioner shall, within available resources, 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;

(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 under sections 245D.05, 245D.06, 245D.07, 245D.071, 245D.081, and 245D.09, and for services provided by a license holder certified under section 245D.33.

(b) The commissioner, in consultation with stakeholders, shall review and evaluate 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;

(2) values for services where monitoring technology replaces staff time;

(3) values for indirect services;

(4) values for nursing;

(5) values for the facility use rate in day services, and the weightings used in the day service ratios and adjustments to those weightings;

(6) values for workers' compensation as part of employee-related expenses;

(7) values for unemployment insurance as part of employee-related expenses;

(8) direct care workforce labor market measures;

(9) any changes in state or federal law with a direct impact on the underlying cost of providing home and community-based services;

(10) outcome measures, determined by the commissioner, for home and community-based services rates determined under this section; and

(11) different competitive workforce factors by service, as determined under subdivision 10b.

(c) Beginning July 1, 2022, the commissioner shall renew analysis and implement changes to the regional adjustment factors once every six years. Prior to implementation, the commissioner shall consult with stakeholders on the methodology to calculate the adjustment.

Subd. 10a. **Reporting and analysis of cost data.** (a) The commissioner must ensure that wage values and component values in subdivisions 5 to 9 reflect the cost to provide the service. As determined by the commissioner, in consultation with community partners identified in subdivision 17, a provider enrolled to provide services with rates determined under this section must submit requested cost data to the commissioner to support research on the cost of providing services that have rates determined by the disability waiver rates system. Requested cost data may include, but is not limited to:

(1) worker wage costs;

(2) benefits paid;

(3) supervisor wage costs;

(4) executive wage costs;

(5) vacation, sick, and training time paid;

(6) taxes, workers' compensation, and unemployment insurance costs paid;

(7) administrative costs paid;

(8) program costs paid;

(9) transportation costs paid;

(10) vacancy rates; and

(11) other data relating to costs required to provide services requested by the commissioner.

(b) At least once in any five-year period, a provider must submit cost data for a fiscal year that ended not more than 18 months prior to the submission date. The commissioner shall provide each provider a 90-day notice prior to its submission due date. The commissioner may review report submissions for inaccurate, inconclusive, incomplete, or otherwise deficient data and may remove the report from submitted status for further verification. If a provider fails to submit required reporting data, the commissioner shall provide notice to providers that have not provided required data 30 days after the required submission date, and a second notice for providers who have not provided required data 60 days after the required submission date. The commissioner shall temporarily suspend payments to the provider if cost data is not received 90

days after the required submission date. Withheld payments shall be made once data is received and reviewed for compliance by the commissioner.

(c) The commissioner shall conduct a random validation of data submitted under paragraph (a) to ensure data accuracy. Providers selected to validate cost reports must respond to the commissioner within 30 days with the requested financial documentation. If a provider fails to respond to the commissioner with all the requested information within 30 days, the commissioner must temporarily suspend payments. The commissioner must resume payments once the requested documentation is received. If a provider is unable to validate the provider's costs with supporting documentation, the commissioner must require the provider to participate in the random validation the next year that the commissioner selects providers to report their costs. The commissioner shall analyze cost documentation in paragraph (a) and provide recommendations for adjustments to cost components.

(d) The commissioner shall analyze cost data submitted under paragraph (a). The commissioner shall release cost data in an aggregate form. Cost data from individual providers must not be released except as provided for in current law.

(e) Beginning January 1, 2029, the commissioner shall use data collected in paragraph (a) to determine the compliance with requirements identified under subdivision 10d. The commissioner shall identify providers who have not met the thresholds identified under subdivision 10d on the Department of Human Services website for the year for which the providers reported their costs.

Subd. 10b. **Provider submission of labor market data.** (a) Providers enrolled to provide services with rates determined under section 256B.4914, subdivision 3, shall submit labor market data to the commissioner annually on or before November 1, including but not limited to:

(1) number of direct care staff;

(2) wages of direct care staff;

(3) overtime wages of direct care staff;

(4) hours worked by direct care staff;

(5) overtime hours worked by direct care staff;

(6) benefits provided to direct care staff;

(7) direct care staff job vacancies; and

(8) direct care staff retention rates.

(b) The commissioner shall publish annual reports on provider and state-level labor market data, including but not limited to the data obtained under paragraph (a).

(c) The commissioner may temporarily suspend payments to the provider if data requested under paragraph (a) is not received 90 days after the required submission date. Withheld payments shall be made once data is received by the commissioner.

(d) Providers who receive payment under this section for less than 25 percent of their clients in the year prior to the report may attest to the commissioner in a manner determined by the commissioner that they are declining to provide the data required under paragraph (a) and will not be subject to the payment suspension in paragraph (c).

Subd. 10c. **Reporting and analysis of competitive workforce factor.** (a) Beginning February 1, 2025, and every two years thereafter, the commissioner shall report to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services policy and finance an analysis of the competitive workforce factor.

(b) The report must include:

(1) the most recently available wage data by SOC code for the weighted average wage for direct care staff for residential services and direct care staff for day services;

(2) the most recently available wage data by SOC code of the weighted average wage of comparable occupations; and

(3) workforce data as required under subdivision 10b.

(c) This subdivision expires June 30, 2031.

Subd. 10d. **Direct care staff; compensation.** (a) A provider paid with rates determined under subdivision 6 must use a minimum of 66 percent of the revenue generated by rates determined under that subdivision for direct care staff compensation.

(b) A provider paid with rates determined under subdivision 7 must use a minimum of 45 percent of the revenue generated by rates determined under that subdivision for direct care staff compensation.

(c) A provider paid with rates determined under subdivision 8 or 9 must use a minimum of 60 percent of the revenue generated by rates determined under those subdivisions for direct care staff compensation.

(d) Compensation under this subdivision includes:

(1) wages;

(2) taxes and workers' compensation;

(3) health insurance;

(4) dental insurance;

(5) vision insurance;

(6) life insurance;

(7) short-term disability insurance;

(8) long-term disability insurance;

(9) retirement spending;

(10) tuition reimbursement;

(11) wellness programs;

(12) paid vacation time;

(13) paid sick time; or

(14) other items of monetary value provided to direct care staff.

(e) This subdivision does not apply to a provider licensed as an assisted living facility by the commissioner of health under chapter 144G.

(f) This subdivision is effective January 1, 2029, and applies to services provided on or after that date.

Subd. 10e. **Documentation of staffing; auditing and rate review.** (a) Effective for services provided on or after January 1, 2029, a provider enrolled to provide residential support services under subdivision 6 must maintain documentation of direct staffing hours provided to each person receiving services, including but not limited to documentation identifying:

(1) the name, role, and unique identifier for each staff person who provided services to match records to payroll, time and attendance systems, and any other source documentation;

(2) the date services were provided;

(3) the total number of hours of direct support provided;

(4) awake overnight staffing hours provided, if applicable;

(5) asleep overnight staffing hours provided, if applicable; and

(6) any other staffing information required by the commissioner.

(b) A provider must maintain documentation in a manner and format determined by the commissioner for at least six years. If a provider changes payroll vendors, merges operations, or changes staffing identifiers, the provider must maintain a documented link between prior and current staffing identifiers sufficient to allow tracking of hours worked, turnover, and role classification for each staff person.

(c) A provider must submit the documentation required under paragraph (a) to the commissioner annually, in a manner and format determined by the commissioner. The commissioner must establish multiple submission windows throughout the calendar year and may assign providers to a submission window for administrative efficiency and system capacity. Documentation must reflect staffing provided during the prior calendar year and must be submitted no later than the final business day of the provider's assigned submission window. The commissioner may conduct random or targeted validations and audits of submitted data and may require supplemental documentation as necessary to verify accuracy and compliance.

(d) The commissioner must conduct periodic analysis of documentation submitted under this subdivision and may validate staffing data through random audits or other verification methods.

(e) Based on the analysis under paragraph (d), the commissioner may provide recommendations to lead agencies regarding modifications to the rate of a person receiving services, including increases or decreases necessary to align the rate with staffing provided to the person as demonstrated by the submitted historical staffing documentation. Recommendations must be based on the requirements of this section and applicable federal and state requirements governing rate setting.

(f) If a provider fails to submit documentation requested within the submission window in paragraph (c), the commissioner must issue a written notice of noncompliance. If documentation is not received within 60 days following the notice of noncompliance, the commissioner may temporarily suspend payments to the provider until the required documentation is submitted. The commissioner must make withheld payments to the provider once the required documentation is received. If the noncompliance persists, the commissioner may adjust future rate payments, require the provider to submit a corrective action plan, or pursue other enforcement actions as authorized by law.

(g) The commissioner must publish annual aggregate reports summarizing audit findings and trends related to staffing provided under this section.

Subd. 11. MS 2020 [Repealed by amendment, 2022 c 33 s 1]

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 to 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:

(i) an assessment score which indicates a hearing impairment that is severe or that the person has no useful hearing;

(ii) 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

(iii) 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

(2) the person receives long-term care services and has an assessment score that indicates the person hears only very loud sounds, the person has 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. Effective January 1, 2027, or upon federal approval, whichever is later, the billing limit for waiver transportation is equal to a maximum of 28 one-way trips per week per participant.

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. Whether granted, denied, or modified, the commissioner shall respond to all exception requests in writing. The commissioner shall include in the written response the basis for the action and provide notification of the right to appeal under paragraph (h).

(b) Lead agencies must act on an exception request within 30 days and notify the initiator of the request of their recommendation in writing. A lead agency shall submit all exception requests along with its recommendation to the commissioner.

(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;

(2) an individual's rate determined under subdivisions 6 to 9 is so insufficient that it has resulted in an individual receiving a notice of discharge from the individual's provider; or

(3) an individual's service needs, including behavioral changes, require a level of service which necessitates a change in provider or which requires the current provider to propose service changes beyond those currently authorized.

(d) Exception requests must include the following information:

(1) the service needs required by each individual that are not accounted for in subdivisions 6 to 9;

(2) the service rate requested and the difference from the rate determined in subdivisions 6 to 9;

(3) a basis for the underlying costs used for the rate exception and any accompanying documentation; and

(4) 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, an interested party, or the license holder that would receive the rate exception increase may request that a lead agency submit an exception request. A lead agency that denies such a request shall notify the individual waiver recipient, interested party, or license holder of its decision and the reasons for denying the request in writing no later than 30 days after the request has been made and shall submit its denial to the commissioner in accordance with paragraph (b). The reasons for the denial must be based on the failure to meet the criteria in paragraph (c).

(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, the interested party, and the license holder 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.

(j) The starting date for the rate exception will be the later of the date of the recipient's change in support or the date of the request to the lead agency for an exception.

(k) The commissioner shall track all exception requests received and their dispositions. The commissioner shall issue quarterly public exceptions statistical reports, including the number of exception requests received and the numbers granted, denied, withdrawn, and pending. The report shall include the average amount of time required to process exceptions.

(l) Approved rate exceptions remain in effect in all cases until an individual's needs change as defined in paragraph (c).

(m) Rates determined under subdivision 19 are ineligible for rate exceptions.

[See Note.]

Subd. 14a. **Limitations on rate exceptions for residential services.** (a) Effective July 1, 2026, the commissioner must implement limitations on the rate exceptions for community residential services, customized living services, family residential services, and integrated community supports.

(b) The commissioner must restrict rate exceptions to the absence and utilization factor ratio to people temporarily receiving hospital or crisis respite services.

(c) For rate exceptions related to behavioral needs, the lead agency must include:

(1) a documented behavioral diagnosis; or

(2) determined assessed needs for behavioral supports as identified in the person's most recent assessment or reassessment under section 256B.0911.

(d) Community residential services rate exceptions must not include positive support services costs.

(e) The commissioner must not approve rate exception requests related to increased community time or transportation.

(f) For the commissioner to approve a rate exception annual renewal, the person's most recent assessment must indicate continued extraordinary needs in the areas cited in the exception request. If a person's assessment continues to identify these extraordinary needs, lead agencies requesting an annual renewal of rate exceptions must submit documentation supporting the continuation of the exception. At a minimum, documentation must include:

(1) payroll records for direct care wages cited in the request;

(2) payment records or receipts for other costs cited in the request; and

(3) documentation of expenses paid that were identified as necessary for the initial rate exception.

(g) The commissioner must not increase rate exception annual renewals that request an exception to direct care or supervision wages more than the most recently implemented update to the base wage index under subdivision 5b.

(h) The commissioner must publish online an annual report detailing the impact of the limitations under this subdivision on home and community-based services spending, including but not limited to:

(1) the number and percentage of rate exceptions granted and denied;

(2) total spending on community residential setting services and rate exceptions;

(3) trends in the percentage of spending attributable to rate exceptions; and

(4) an evaluation of the effectiveness of the limitations in controlling spending growth.

[See Note.]

Subd. 15. **County or Tribal allocations.** (a) 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) 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) Lead agencies exceeding their allocations shall be subject to the provisions under sections 256B.0916, subdivision 11, and 256B.49, subdivision 26.

Subd. 16. MS 2016 [Repealed, 1Sp2017 c 6 art 1 s 54]

Subd. 17. **Community consultation and training.** (a) The commissioner shall continue consultation at regular intervals with the DWRS advisory committee established as part of the rate-setting methodology process and other community partners, to gather input, concerns, and data, to assist in the implementation of the rate payment system, and to make pertinent information available to the public through the department's website.

(b) The commissioner shall offer training at least annually for county personnel responsible for administering the rate-setting framework in a manner consistent with this section.

(c) The commissioner shall maintain an online instruction manual explaining the rate-setting framework. The manual must be consistent with this section, and must be accessible to recipients, representatives of recipients, county or Tribal agencies, and license holders.

(d) The commissioner shall not defer to the county or Tribal agency on matters of technical application of the rate-setting framework, and a county or Tribal agency must not set rates in a manner that conflicts with this section.

(e) The commissioner must consult with the DWRS advisory committee and other community partners as required under this subdivision to periodically review, update, and revise the format by which initiators of rate exception requests and lead agencies collect and submit information about individuals with exceptional needs under subdivision 14.

Subd. 18. **Legislatively approved changes; public notice.** (a) The commissioner shall provide a public notice via LISTSERV in October of each year 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

(4) information on adjustments made to calculation values and the timing of those adjustments.

(b) The information in this notice must be effective January 1 of the following year.

Subd. 19. **Payments for family residential and life sharing services.** The commissioner shall establish rates for family residential services and life sharing services based on a person's assessed need, as described in the federally-approved waiver plans. Rates for life sharing services must be ten percent higher than the corresponding family residential services rate.

[See Note.]

Subd. 20. **Sanctions and monetary recovery.** Payments under this section are subject to the sanctions and monetary recovery requirements under section 256B.064.

Subd. 21. **Integrated community supports access services; service standards and billing criteria.** (a) This subdivision is effective October 1, 2027, or upon federal approval, whichever is later.

(b) For the purposes of this section, "integrated community supports access services" means the on-site or on-call availability of trained staff to address an individual's incidental, unplanned support needs in an integrated community supports setting.

(c) A provider billing integrated community supports access services for on-call staff must ensure that on-call staff are only assigned to one setting and can respond in-person to the setting within 30 minutes of receiving a request for support. A provider must ensure that staff providing on-site or on-call availability are specifically trained to support the individual for each integrated community supports access services unit billed.

(d) Providers must collect and maintain documentation on each instance of incidental, unplanned support provided to an individual by on-site or on-call staff. A documented instance of staff providing incidental, unplanned support is not required for each day the integrated community supports access services unit is billed.

(e) Documentation required under this subdivision must include:

(1) the individual's name;

(2) the date and time the individual requested incidental, unplanned support from on-site or on-call staff;

(3) the date and time of the incidental, unplanned support provision;

(4) the name of the staff member providing the incidental, unplanned support;

(5) a description of what incidental, unplanned support was provided; and

(6) an indication if provision of incidental, unplanned support did or did not result in the need for direct one-to-one support billed under subdivision 8a.

(f) A provider must document each instance of incidental, unplanned support provision within 72 hours. If documentation is completed more than 72 hours after provision of incidental, unplanned support, the provider must document extenuating circumstances that resulted in the delay in documentation under this subdivision.

(g) Documentation must be maintained either electronically or in paper form. The provider must produce the documentation upon request by the commissioner or lead agency.

Subd. 22. **Administrative fees charged by providers and vendors.** Effective July 1, 2027, or upon federal approval, whichever is later, the commissioner must limit administrative fees charged by enrolled providers and vendors approved by lead agencies to no more than six percent of the total cost of the service or purchased goods. This limit applies to the following services and other new market rate services as determined by the commissioner:

(1) chore services billed daily;

(2) transitional services; and

(3) transportation.

History: *2013 c 108 art 13 s 12; 2014 c 312 art 27 s 62-69; 2015 c 71 art 7 s 37-42; 2016 c 158 art 1 s 126; 2017 c 90 s 21-24; 1Sp2017 c 6 art 1 s 22-31; 2019 c 50 art 2 s 1; 1Sp2019 c 9 art 5 s 56-68; 1Sp2021 c 7 art 13 s 42,43; 2022 c 33 s 1; 2022 c 98 art 17 s 26; 2023 c 50 art 4 s 6; 2023 c 61 art 1 s 27-47; 2024 c 108 art 1 s 18; art 6 s 2,3; 2025 c 38 art 1 s 21-23; 1Sp2025 c 9 art 2 s 30-37; 1Sp2025 c 11 s 6; 2026 c 95 art 4 s 28; 2026 c 121 art 9 s 23-38*

NOTE: The amendment to subdivision 3, by Laws 2023, chapter 61, article 1, section 27, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2023, chapter 61, article 1, section 27, the effective date.

NOTE: The amendments to subdivisions 6a, 6b, 6c, 7a, 7b, 7c, 8, and 9, by Laws 2023, chapter 61, article 1, sections 33 to 40, are effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2023, chapter 61, article 1, sections 33 to 40, the effective dates.

NOTE: The amendments to subdivision 5b by Laws 2025, First Special Session chapter 9, article 2, section 33, are effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2025, First Special Session chapter 9, article 2, section 33, the effective date.

NOTE: The service name changes in subdivisions 5a, clauses (7), (11), and (12); 6a; 6c; 7b; and 7c, made by Laws 2019, First Special Session chapter 9, article 5, section 59, are effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2019, First Special Session chapter 9, article 5, section 59, the effective date.

NOTE: The amendments to subdivision 5a, clause (4), by Laws 2023, chapter 61, article 1, section 30, are effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2023, chapter 61, article 1, section 30, the effective date.

NOTE: The amendments to subdivision 5b by Laws 2023, chapter 61, article 1, section 31, are effective upon federal approval, except that the amendments to clauses (2) and (3) became effective January 1, 2024. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2023, chapter 61, article 1, section 31, the effective date.

NOTE: The amendment to subdivision 6 by Laws 2023, chapter 61, article 1, section 32, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2023, chapter 61, article 1, section 32, the effective date.

NOTE: Subdivision 6b is repealed by Laws 2023, chapter 61, article 1, section 85, effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2023, chapter 61, article 1, section 85, the effective date.

NOTE: Subdivision 9a is repealed by Laws 2023, chapter 61, article 1, section 85, effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2023, chapter 61, article 1, section 85, the effective date.

NOTE: The amendments to subdivision 14, paragraph (m), by Laws 2023, chapter 61, article 1, section 46, are effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2023, chapter 61, article 1, section 46, the effective date.

NOTE: Subdivision 14a, as added by Laws 2025, First Special Session chapter 9, article 2, section 36, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2025, First Special Session chapter 9, article 2, section 36, the effective date.

NOTE: Subdivision 19, as added by Laws 2023, chapter 61, article 1, section 47, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2023, chapter 61, article 1, section 47, the effective date.

256B.492 HOME AND COMMUNITY-BASED SETTINGS FOR PEOPLE WITH DISABILITIES.

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

(b) "Community-living setting" means a single-family home or multifamily dwelling unit where a service recipient or a service recipient's family owns or rents and maintains control over the individual unit as demonstrated by a lease agreement. Community-living setting does not include a home or dwelling unit that the provider of the service recipient's services owns, operates, or leases or in which the provider of the service recipient's services has a direct or indirect financial interest.

(c) "Controlling individual" has the meaning given in section 245A.02, subdivision 5a.

(d) "License holder" has the meaning given in section 245A.02, subdivision 9.

Subd. 2. **Home and community-based waiver settings.** (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) home and community-based settings that comply with all requirements identified by the federal Centers for Medicare and Medicaid Services in the Code of Federal Regulations, title 42, section 441.301(c), and with the requirements of the federally approved transition plan and waiver plans for each home and community-based services waiver; and

(2) settings required by the Housing Opportunities for Persons with AIDS Program.

(b) The settings in paragraph (a) must not 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.

Subd. 3. **Community-living settings.** (a) Individuals receiving services under a home and community-based waiver under section 256B.092 or 256B.49 may receive services in community-living settings. Community-living settings must meet the requirements of subdivision 2, paragraph (a), clause (1).

(b) For the purposes of this section, direct financial interest exists if payment passes between the license holder or any controlling individual of a licensed program and the service recipient or an entity acting on the service recipient's behalf for the purpose of obtaining or maintaining a dwelling. For the purposes of this section, indirect financial interest exists if the license holder or any controlling individual of a licensed program has an ownership or investment interest in the entity that owns, operates, leases, or otherwise receives payment from the service recipient or an entity acting on the service recipient's behalf for the purpose of obtaining or maintaining a dwelling. Neither a direct nor an indirect financial interest exists if the service

recipient is receiving services from a license holder or a licensed program that is not the license holder or a licensed program that owns, operates, leases, or has a direct or indirect financial interest in the setting in which the service recipient's services are being delivered.

(c) To ensure a service recipient or the service recipient's family maintains control over the home or dwelling unit, community-living settings are subject to the following requirements:

(1) service recipients must not be required to receive services or share services;

(2) service recipients must not be required to have a disability or specific diagnosis to live in the community-living setting;

(3) service recipients may hire service providers of their choice;

(4) service recipients may choose whether to share their household and with whom;

(5) the home or multifamily dwelling unit must include living, sleeping, bathing, and cooking areas;

(6) service recipients must have lockable access and egress;

(7) service recipients must be free to receive visitors and leave the settings at times and for durations of their own choosing;

(8) leases must comply with chapter 504B;

(9) landlords must not charge different rents to tenants who are receiving home and community-based services; and

(10) access to the greater community must be easily facilitated based on the service recipient's needs and preferences.

(d) Nothing in this section prohibits a service recipient from having another person or entity not affiliated with the service provider cosign a lease. Nothing in this section prohibits a service recipient, during any period in which a service provider has cosigned the service recipient's lease, from modifying services with an existing cosigning service provider and, subject to the approval of the landlord, maintaining a lease cosigned by the service provider. Nothing in this section prohibits a service recipient, during any period in which a service provider has cosigned the service recipient's lease, from terminating services with the cosigning service provider, receiving services from a new service provider, or, subject to the approval of the landlord, maintaining a lease cosigned by the new service provider.

(e) A lease cosigned by a service provider meets the requirements of paragraph (b) if the service recipient and service provider develop and implement a transition plan which must provide that, within two years of cosigning the initial lease, the service provider shall transfer the lease to the service recipient and other cosigners, if any.

(f) In the event the landlord has not approved the transfer of the lease within two years of the service provider cosigning the initial lease, the service provider must submit a time-limited extension request to the commissioner of human services to continue the cosigned lease arrangement. The extension request must include:

(1) the reason the landlord denied the transfer;

(2) the plan to overcome the denial to transfer the lease;

(3) the length of time needed to successfully transfer the lease, not to exceed an additional two years;

(4) a description of how the transition plan was followed, what occurred that led to the landlord denying the transfer, and what changes in circumstances or condition, if any, the service recipient experienced; and

(5) a revised transition plan to transfer the cosigned lease between the service provider and the service recipient to the service recipient.

(g) The commissioner must approve an extension under paragraph (f) within sufficient time to ensure the continued occupancy by the service recipient.

Subd. 4. **Integrated community supports setting approval moratorium and exception.** (a) For purposes of this subdivision, "integrated community supports setting" means a multifamily housing building where a provider delivers integrated community supports under section 245D.03, subdivision 1, paragraph (c), clause (8), and for which a provider has a provider-controlled or provider-associated financial interest as defined under section 245A.02, subdivision 10b.

(b) The commissioner must not approve a new integrated community supports setting or approve an expansion of an existing integrated community supports setting except as provided in this subdivision.

(c) The commissioner may approve an exception to the moratorium only when the applicant demonstrates indirect control of the setting and compliance with:

(1) the federal home and community-based services requirements under Code of Federal Regulations, title 42, section 441.301(c);

(2) the prohibition on the use of medical assistance money for room and board under section 256B.4912, subdivision 17;

(3) independent lease requirements consistent with chapter 504B; and

(4) all documentation requirements under section 245D.12.

(d) To approve an exception, the commissioner must determine that the lead agency has requested the additional capacity to meet the specific disability-related needs of the person. Priority must be given to geographic regions with insufficient integrated community supports capacity based on statewide or regional needs determination processes.

(e) Nothing in this subdivision authorizes the commissioner to revoke approval of a previously approved setting following a change of ownership permissible under section 245A.043.

(f) A determination under this subdivision is final and not subject to appeal.

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; 2015 c 71 art 7 s 43; 2023 c 50 art 1 s 30; 2026 c 95 art 8 s 4,5; 2026 c 121 art 9 s 39*

NOTE: The amendments to this section by Laws 2023, chapter 50, article 1, section 30, are effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2023, chapter 50, article 1, section 30, the effective date.

256B.493 ADULT FOSTER CARE PLANNED CLOSURE.

Subdivision 1. **Commissioner's duties; report.** The commissioner of human services has the authority to manage statewide licensed corporate foster care or community residential settings capacity, including the

reduction and realignment of licensed capacity of a current foster care or community residential setting to accomplish the consolidation or closure of settings. The commissioner shall implement a program for planned closure of licensed corporate adult foster care or community residential settings, necessary as a preferred method to respond to the informed decisions of those individuals who want to move out of these settings into other types of community settings.

Subd. 2. **Planned closure process needs determination.** A resource need determination process, managed at the state level, using available data required by section 144A.351 and other data and information shall be used by the commissioner to align capacity where needed.

Subd. 2a. **Closure process.** (a) The commissioner shall work with stakeholders to establish a process for the application, review, approval, and implementation of setting closures. Voluntary proposals from license holders for consolidation and closure of adult foster care or community residential settings are encouraged. Whether voluntary or involuntary, all closure plans must include:

(1) a description of the proposed closure plan, identifying the home or homes and occupied beds;

(2) the proposed timetable for the proposed closure, including the proposed dates for notification to people living there 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 people living there 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 from the provider in a format approved by the commissioner that all the adult foster care homes or community residential settings receiving a planned closure rate adjustment under the plan have accepted joint and severable for recovery of overpayments under section 256B.0641, subdivision 2, for the facilities designated for closure under this plan.

(b) The commissioner shall give first priority to closure plans which:

(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 licensed corporate foster care or community residential settings; 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 people using services, their legal representatives, family members, or the lead agency on the impact of the planned closure on people and the services they need.

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;

(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.

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.

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; 1Sp2017 c 6 art 2 s 16-18; 2022 c 98 art 14 s 23; 2023 c 50 art 1 s 31,32; 2026 c 95 art 4 s 29*

256B.495 Subdivision 1. MS 2015 Supp [Repealed, 2016 c 99 art 1 s 43]

Subd. 1a. MS 2014 [Repealed, 2015 c 74 s 13]

Subd. 2. MS 2014 [Repealed, 2015 c 74 s 13]

Subd. 3. MS 1990 [Repealed, 1992 c 513 art 8 s 59]

Subd. 4. MS 2014 [Repealed, 2015 c 74 s 13]

Subd. 5. MS 2015 Supp [Repealed, 2016 c 99 art 1 s 43]

256B.50 APPEALS.

Subdivision 1. **Scope.** A provider may appeal from a determination of a payment rate established pursuant to this chapter or allowed costs under chapter 256R 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 256R.54. 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 144.0724.

Subd. 1a. **Definitions.** (a) For the purposes of this section, the following terms have the meanings given.

(b) "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.

(c) "Provider" means a nursing facility as defined in section 256R.02, subdivision 33, or a facility as defined in section 256B.501, subdivision 1.

(d) The definitions in section 256R.02 apply to this section.

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 publication date printed on the rate notice. 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 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.421, 256B.431, 256B.48, 256B.501, 256B.502, 256R.01, 256R.06, 256R.11, and 256R.12, 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. MS 1996 [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 Court of Administrative Hearings, and direct administrative costs of the department; and "substantially justified" means that a position had a reasonable basis in law and fact, based on the totality of the circumstances prior to and during the contested case proceeding and subsequent review.

(b) When an award is made to the department under this subdivision, attorney fees must be calculated at the cost to the department. When an award is made to a provider under this subdivision, attorney fees must be calculated at the rate charged to the provider except that attorney fees awarded must be the lesser of the attorney's normal hourly fee or $100 per hour.

(c) In contested case proceedings involving more than one issue, the administrative law judge shall determine what portion of each party's attorney fees and costs is related to the issue or issues on which it prevailed and for which it is entitled to an award. In making that determination, the administrative law judge shall consider the amount of time spent on each issue, the precedential value of the issue, the complexity of the issue, and other factors deemed appropriate by the administrative law judge.

(d) When the department prevails on an issue involving more than one provider, the administrative law judge shall allocate the total amount of any award for attorney fees and costs among the providers. In determining the allocation, the administrative law judge shall consider each provider's monetary interest in the issue and other factors deemed appropriate by the administrative law judge.

(e) Attorney fees and costs awarded to the department for proceedings under this subdivision must not be reported or treated as allowable costs on the provider's cost report.

(f) Fees and costs awarded to a provider for proceedings under this subdivision must be reimbursed to them within 120 days of the final decision on the award of attorney fees and costs.

(g) If the provider fails to pay the awarded attorney fees and costs within 120 days of the final decision on the award of attorney fees and costs, the department may collect the amount due through any method available to it for the collection of medical assistance overpayments to providers. Interest charges must be assessed on balances outstanding after 120 days of the final decision on the award of attorney fees and costs. The annual interest rate charged must be the rate charged by the commissioner of revenue for late payment of taxes that is in effect on the 121st day after the final decision on the award of attorney fees and costs.

(h) Amounts collected by the commissioner pursuant to this subdivision must be deemed to be recoveries pursuant to section 256.01, subdivision 2, paragraph (n).

(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. MS 1996 [Repealed, 1997 c 107 s 19]

Subd. 1h. MS 1996 [Repealed, 1997 c 107 s 19]

Subd. 2. MS 1996 [Repealed, 1997 c 107 s 19]

Subd. 3. MS 1998 [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 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; 2015 c 71 art 6 s 39; 2015 c 78 art 4 s 61; 2016 c 99 art 2 s 9; 2016 c 158 art 1 s 127,128; 2017 c 40 art 1 s 74,75; 1Sp2017 c 6 art 3 s 25; 2023 c 25 s 144; 2025 c 39 art 2 s 68*

256B.501 RATES FOR COMMUNITY-BASED SERVICES FOR PERSONS WITH DISABILITIES.

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

(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. MS 2012 [Repealed, 2014 c 262 art 4 s 9]

Subd. 3b. MS 2012 [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 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. MS 1994 [Repealed, 1995 c 207 art 7 s 43]

Subd. 3e. MS 1994 [Repealed, 1995 c 207 art 7 s 43]

Subd. 3f. MS 1994 [Repealed, 1995 c 207 art 7 s 43]

Subd. 3g. MS 1998 [Repealed, 1999 c 245 art 3 s 51]

Subd. 3h. MS 2012 [Repealed, 2014 c 262 art 4 s 9]

Subd. 3i. **Scope.** Subdivision 3c does not apply to facilities whose payment rates are governed by Minnesota Rules, part 9553.0075.

Subd. 3j. MS 2012 [Repealed, 2014 c 262 art 4 s 9]

Subd. 3k. MS 2012 [Repealed, 2014 c 262 art 4 s 9]

Subd. 3l. MS 2012 [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 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 housing support 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 housing support payment available. The adjustment to the waiver rates shall be based on county reports of service costs that are no longer eligible for housing support payments. No adjustment shall be made for any amount of reported payments that prior to July 1, 1992, exceeded the housing support 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. MS 1986 [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;

(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

(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. MS 2013 Supp [Repealed, 2014 c 262 art 4 s 9]

Subd. 5c. MS 1996 [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. MS 2012 [Repealed, 2014 c 262 art 4 s 9]

Subd. 6. MS 1986 [Repealed, 1987 c 403 art 5 s 22]

Subd. 7. MS 1986 [Repealed, 1987 c 403 art 5 s 22]

Subd. 8. MS 2012 [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 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. MS 1986 [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 chapter 245D 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 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.

(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 246C.11.

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.

(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.

(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; 2016 c 158 art 1 s 129; 2017 c 40 art 1 s 76,77; 1Sp2017 c 6 art 2 s 39; 2024 c 79 art 10 s 2*

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;

(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. MS 1998 [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 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. 3a. **Therapeutic leave days.** Notwithstanding Minnesota Rules, part 9505.0415, subpart 7, a vacant bed in an intermediate care facility for persons with developmental disabilities shall be counted as a reserved bed when determining occupancy rates and eligibility for payment of a therapeutic leave day.

Subd. 4. MS 2024 [Repealed, 2026 c 95 art 4 s 42]

Subd. 5. MS 2024 [Repealed, 2026 c 95 art 4 s 42]

Subd. 6. MS 2024 [Repealed, 2026 c 95 art 4 s 42]

Subd. 7. MS 2024 [Repealed, 2026 c 95 art 4 s 42]

Subd. 8. MS 2024 [Repealed, 2026 c 95 art 4 s 42]

Subd. 9. MS 2024 [Repealed, 2026 c 95 art 4 s 42]

Subd. 10. MS 2024 [Repealed, 2026 c 95 art 4 s 42]

Subd. 11. MS 2024 [Repealed, 2026 c 95 art 4 s 42]

Subd. 12. MS 2024 [Repealed, 2026 c 95 art 4 s 42]

Subd. 13. MS 2012 [Repealed, 2013 c 108 art 7 s 64]

Subd. 14. MS 2024 [Repealed, 2026 c 95 art 4 s 42]

Subd. 15. MS 2024 [Repealed, 2026 c 95 art 4 s 42]

Subd. 16. MS 2024 [Repealed, 2026 c 95 art 4 s 42]

Subd. 17. **ICF/DD rate increase effective July 1, 2017; Murray County.** Effective July 1, 2017, the daily rate for an intermediate care facility for persons with developmental disabilities located in Murray County that is classified as a class B facility and licensed for 14 beds is $400. This increase is in addition to any other increase that is effective on July 1, 2017.

Subd. 18. **ICF/DD rate increases effective January 1, 2022.** (a) For the rate period beginning January 1, 2022, the commissioner must increase operating payments for each facility reimbursed under this section equal to five percent of the operating payment rates in effect on December 31, 2021.

(b) For each facility, the commissioner must 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 December 31, 2021. The total rate increase must include the adjustment provided in section 256B.501, subdivision 12.

Subd. 19. **ICF/DD rate increase effective January 1, 2024.** (a) Effective January 1, 2024, the daily operating payment rate for a class A intermediate care facility for persons with developmental disabilities is increased by $40.

(b) Effective January 1, 2024, the daily operating payment rate for a class B intermediate care facility for persons with developmental disabilities is increased by $40.

Subd. 20. **ICF/DD minimum daily operating payment rates.** (a) The minimum daily operating payment rate for a class A intermediate care facility for persons with developmental disabilities is $275.

(b) The minimum daily operating payment rate for a class B intermediate care facility for persons with developmental disabilities is $316.

Subd. 21. **ICF/DD rate increases after January 1, 2025.** Beginning January 1, 2025, and every year thereafter, the rates under this section must be updated for the percentage change in the Consumer Price Index (CPI-U) from the previous July 1 to the data available 12 months and one day prior.

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; 1Sp2017 c 6 art 3 s 26,27; 1Sp2021 c 7 art 13 s 44; 2023 c 61 art 1 s 48-50*

256B.5013 PAYMENT RATE ADJUSTMENTS.

Subdivision 1. **Variable rate adjustments.** (a) 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 for crisis intervention services under section 256B.501, subdivision 8a. Once approved, variable rate adjustments must continue to remain in place unless there is an identified change in need. A review of needed resources must be done at the time of the individual's annual support plan meeting. Any change in need identified must result in submission of a request to adjust the resources for the individual. Variable rate adjustments approved solely on the basis of changes on a developmental disabilities screening document will end June 30, 2002.

(b) The county of financial responsibility must act on a variable rate request within 30 days and notify the initiator of the request of the county's recommendation in writing.

(c) 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 that 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;

(4) a demonstrated behavioral or cognitive need that significantly impacts the type or amount of services needed by the individual; or

(5) a demonstrated increased need for staff assistance, changes in the type of staff credentials needed, or a need for expert consultation based on assessments conducted prior to the annual support plan meeting.

(d) Variable rate requests must include the following information:

(1) the service needs change;

(2) the variable rate requested and the difference from the current rate;

(3) a basis for the underlying costs used for the variable rate and any accompanying documentation; and

(4) documentation of the expected outcomes to be achieved and the frequency of progress monitoring associated with the rate increase.

Subd. 2. MS 2008 [Repealed, 2009 c 159 s 112]

Subd. 3. MS 2008 [Repealed, 2009 c 159 s 112]

Subd. 4. MS 2002 [Repealed, 1Sp2003 c 14 art 3 s 60]

Subd. 5. MS 2008 [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 determination; 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; 2016 c 158 art 1 s 130; 1Sp2021 c 7 art 13 s 45,46*

256B.5014 REPORTING REQUIREMENTS.

Subdivision 1. **Financial reporting.** All facilities shall maintain financial records and shall provide annual income and expense reports to the commissioner of human services on a form prescribed by the commissioner no later than April 30 of each year in order to receive medical assistance payments. The reports for the reporting year ending December 31 must include:

(1) salaries and related expenses, including program salaries, administrative salaries, other salaries, payroll taxes, and fringe benefits;

(2) general operating expenses, including supplies, training, repairs, purchased services and consultants, utilities, food, licenses and fees, real estate taxes, insurance, and working capital interest;

(3) property related costs, including depreciation, capital debt interest, rent, and leases; and

(4) total annual resident days.

Subd. 2. **Labor market reporting.** All intermediate care facilities shall comply with the labor market reporting requirements described in section 256B.4912, subdivision 1a.

History: *1999 c 245 art 3 s 35; 1Sp2019 c 9 art 5 s 69*

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.** (a) 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. The commissioner shall establish rates for these services, other than day training and habilitation services, at 100 percent of a recipient's day training and habilitation service costs prior to the service change.

(b) An individual qualifies for services during the day under paragraph (a) if, through consultation with the individual and the individual's support team or interdisciplinary team:

(1) it has been determined that the individual's needs can best be met through partial or full retirement from:

(i) participation in a day training and habilitation service; or

(ii) the use of services during the day in the individual's home environment; and

(2) an individualized plan has been developed with designated outcomes that:

(i) address the support needs and desires contained in the person-centered plan or individual support plan; and

(ii) include goals that focus on community integration as appropriate for the individual.

(c) When establishing a rate for these services, the commissioner shall also consider an individual recipient's needs as identified in the individual support 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; 1Sp2021 c 7 art 13 s 47*

256B.5016 MS 2012 [Repealed, 2014 c 262 art 4 s 9]

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 MS 2012 [Repealed, 2014 c 262 art 4 s 9]

256B.504 MS 1994 [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 with a physical disability or persons 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; 2017 c 40 art 1 s 121*

256B.53 MS 2012 [Repealed, 2014 c 262 art 2 s 18]

256B.55 MS 2006 [Expired]

256B.56 MS 1994 [Repealed, 1996 c 310 s 1]

256B.57 MS 1994 [Repealed, 1996 c 310 s 1]

256B.58 MS 1994 [Repealed, 1996 c 310 s 1]

256B.59 MS 1994 [Repealed, 1996 c 310 s 1]

256B.60 MS 1994 [Repealed, 1996 c 310 s 1]

256B.61 MS 1994 [Repealed, 1996 c 310 s 1]

256B.62 MS 1994 [Repealed, 1996 c 310 s 1]

256B.63 MS 1994 [Repealed, 1996 c 310 s 1]

256B.64 MS 2016 [Repealed, 1Sp2017 c 6 art 4 s 67]

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 nonprofit 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.

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 142F and 145A 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. This paragraph expires upon the effective date of paragraph (d).

(d) 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. This paragraph is effective January 1, 2027, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

(e) In the event that a county board or a single entity representing a group of county boards and the commissioner cannot reach agreement regarding: (i) the selection of participating health plans in that county; (ii) contract requirements; or (iii) implementation and enforcement of county requirements including provisions regarding local public health goals, the commissioner shall resolve all disputes after taking into account the recommendations of a three-person mediation panel. The panel shall be composed of one designee of the president of the association of Minnesota counties, one designee of the commissioner of human services, and one 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.

(f) If a county which elects to implement county-based purchasing ceases to implement county-based purchasing, it is prohibited from assuming the responsibility of county-based purchasing for a period of five years from the date it discontinues purchasing.

(g) 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.

(h) 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.

(i) 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;

(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 seriously mentally ill 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;

(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;

(10) persons who are absent from the state for more than 30 consecutive days but still deemed a resident of Minnesota, identified in accordance with section 256B.056, subdivision 1, paragraph (b); and

(11) persons who are enrolled in the reentry demonstration waiver under section 256B.0761.

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.

[See Note.]

Subd. 4a. MS 1995 Supp [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 assistance 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.

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 administrative 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:

(1) 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 for all personal care assistance services under section 256B.0659 and community first services and supports under section 256B.85;

(2) by January 30 of each year that follows a rate increase for any aspect of services under section 256B.0659 or 256B.85, inform the commissioner and the chairs and ranking minority members of the legislative committees with jurisdiction over rates determined under section 256B.851 of the amount of the rate increase that is paid to each personal care assistance provider agency with which the plan has a contract;

(3) use a six-month timely filing standard and provide an exemption to the timely filing timeliness for the resubmission of claims where there has been a denial, request for more information, or system issue;

(4) have in place a prepayment review process for all claims that includes claims edit processing and policies consistent with the procedures under section 256B.0447; and

(5) publish metrics related to program integrity actions and outcomes on a publicly available website.

(e) 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.

(f) 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.

(g) 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.

(h) 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.

(i) The return of the withhold under paragraphs (e) and (f) is not subject to the requirements of paragraph (c).

(j) Managed care plans and county-based purchasing plans shall maintain current and fully executed agreements for all subcontractors, including bargaining groups, for administrative services that are expensed to the state's public health care programs. Subcontractor agreements determined to be material, as defined by the commissioner after taking into account state contracting and relevant statutory requirements, must be in the form of a written instrument or electronic document containing the elements of offer, acceptance, consideration, payment terms, scope, duration of the contract, and how the subcontractor services relate to state public health care programs. Upon request, the commissioner shall have access to all subcontractor documentation under this paragraph. Nothing in this paragraph shall allow release of information that is nonpublic data pursuant to section 13.02.

(k) The commissioner has the right to recover from a managed care plan the full monetary amount of any claims identified as improperly paid during audits or investigations by the commissioner or the commissioner's contractors or the Centers for Medicare and Medicaid Services.

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. MS 2022 [Repealed, 2023 c 70 art 5 s 16]

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. MS 2012 [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) Administrative costs paid to managed care plans and county-based purchasing plans under this section, section 256B.692, and section 256L.12 must not exceed 6.6 percent of total payments made to all managed care plans and county-based purchasing plans in aggregate across all state public health care programs, based on payments expected to be made at the beginning of each calendar year. The commissioner may reduce or eliminate administrative requirements to meet the administrative cost limit. For purposes of this paragraph, administrative costs do not include premium taxes paid under section 297I.05, subdivision 5, provider surcharges paid under section 256.9657, subdivision 3, and health insurance fees under section 9010 of the Affordable Care Act.

(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) compensation of individuals within the organization in excess of $200,000 such that the allocation of compensation for an individual across all state public health care programs in total cannot exceed $200,000;

(3) any penalties or fines assessed against the managed care plan or county-based purchasing plan;

(4) any indirect marketing or advertising expenses of the managed care plan or county-based purchasing plan, including but not limited to costs to promote the managed care or county-based purchasing plan, costs of facilities used for special events, and costs of displays, demonstrations, donations, and promotional items

such as memorabilia, models, gifts, and souvenirs. The commissioner may classify an item listed in this clause as an allowable administrative expense for rate-setting purposes, if the commissioner determines that the expense is incidental to an activity related to state public health care programs that is an allowable cost for purposes of rate setting;

(5) any lobbying and political activities, events, or contributions;

(6) administrative expenses related to the provision of services not covered under the state plan or waiver;

(7) alcoholic beverages and related costs;

(8) membership in any social, dining, or country club or organization; and

(9) entertainment, including amusement, diversion, and social activities, and any costs directly associated with these costs, including but not limited to tickets to shows or sporting events, meals, lodging, rentals, transportation, and gratuities.

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. Charitable contributions under clause (1) include payments for or to any organization or entity selected by the managed care plan or county-based purchasing plan that is operated for charitable, educational, political, religious, or scientific purposes, that are not related to medical and administrative services covered under state public health care programs.

(c) Payments to a quality improvement organization are an allowable administrative expense for rate-setting purposes under this section, to the extent they are allocated to a state public health care program and approved by the commissioner.

(d) Where reasonably possible, expenses for an administrative item shall be directly allocated so as to assign costs for an item to an individual state public health care program when the cost can be specifically identified with and benefits the individual state public health care program. For administrative services expensed to the state's public health care programs, managed care plans and county-based purchasing plans must clearly identify and separately record expense items listed under paragraph (b) in their accounting systems in a manner that allows for independent verification of unallowable expenses for purposes of determining payment rates for state public health care programs.

(e) Notwithstanding paragraph (a), the commissioner shall reduce administrative expenses paid to managed care plans and county-based purchasing plans by .50 of a percentage point for contracts beginning January 1, 2016, and ending December 31, 2017. To meet the administrative reductions under this paragraph, the commissioner may reduce or eliminate administrative requirements, exclude additional unallowable administrative expenses identified under this section and resulting from the financial audits conducted under subdivision 9d, and utilize competitive bidding to gain efficiencies through economies of scale from increased enrollment. If the total reduction cannot be achieved through administrative reduction, the commissioner may limit total rate increases on payments to managed care plans and county-based purchasing plans.

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.** 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.

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 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 chapter 256S. 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. MS 2012 [Repealed, 2014 c 262 art 2 s 18]

Subd. 6d. **Prescription drugs.** (a) 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.

(b) 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. The contracts must require that the managed care plans enter into contracts with the state's selected pharmacy benefit manager vendor to administer the pharmacy benefit.

(c) This subdivision is contingent on federal approval of the managed care contract changes and the collection of additional prescription drug rebates.

(d) The commissioner must require that the final reimbursement to a pharmacy from managed care and county-based purchasing plans and any pharmacy benefit managers under contract with these entities be at least a dispensing fee of $11.55 per claim for prescriptions filled with drugs meeting the definition of covered outpatient drugs. The commissioner must require the payment of a dispensing fee of at least $3.65 for drugs not meeting the definition of covered outpatient drug.

(e) In addition to the dispensing fee set forth in paragraph (d), the commissioner must require that the final reimbursement to a pharmacy from managed care and county-based purchasing plans and any pharmacy benefit managers under contract with these entities be equal to the ingredient cost for a drug as either:

(1) the lower of the National Average Drug Acquisition Cost (NADAC) or the Minnesota actual acquisition cost (MNAAC) under section 256B.0625, subdivision 13, paragraph (g);

(2) the maximum allowable cost, if a drug ingredient cost is unreported in the NADAC and the MNAAC; or

(3) the wholesale acquisition cost minus two percent, if a drug ingredient cost is unreported in the NADAC and the MNAAC and a maximum allowable cost is unavailable.

(f) The commissioner must monitor the effect of this requirement on access to pharmaceutical services in rural and underserved areas of the state. If, for any contract year, federal approval is not received for paragraphs (d) and (e), the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect removal of paragraphs (d) and (e). A contract between a managed care plan or county-based purchasing plan, or any pharmacy benefit manager under contract with one of those entities, and a provider to whom paragraphs (d) and (e) apply must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from paragraphs (d) and (e). This subdivision expires if federal approval is not received for paragraphs (d) and (e) at any time.

(g) Paragraphs (d) to (g) expire upon the effective date of a master contract under section 256B.696. The commissioner shall notify the revisor of statutes of the effective date.

Subd. 6e. **Dental services.** (a) If a dental provider is providing services to an enrollee of a managed care plan or county-based purchasing plan based on a treatment plan that requires more than one visit, the managed care plan or county-based purchasing plan or the plan's subcontractor, if the plan subcontracts with a third party to administer dental services to the plan's enrollees, must not require the completion of the treatment plan as a condition of payment to the dental provider for services performed as part of the treatment plan. The health plan or subcontractor must reimburse the dental provider for all services performed by the provider regardless of whether the treatment plan is completed, as long as the enrollee was covered under the plan at the time the service was performed.

(b) Nothing in paragraph (a) prevents a health plan or its subcontractor from paying for services using a bundled payment method. If a bundled payment method is used and the treatment plan covered by the payment is not completed for any reason, the health plan or its subcontractor must reimburse the dental provider for the services performed, as long as the enrollee was covered under the plan at the time the service was performed.

Subd. 6f. **Dental fee schedules.** (a) A managed care plan, county-based purchasing plan, or dental benefits administrator must provide individual dental providers, upon request, the applicable fee schedules for covered dental services provided under the contract between the dental provider and the managed care plan, county-based purchasing plan, or dental benefits administrator.

(b) A managed care plan, county-based purchasing plan, or dental benefits administrator may fulfill this requirement by making the applicable fee schedules available through a secure web portal for the contracted dental provider to access.

(c) For purposes of this subdivision, "dental benefits administrator" means an organization licensed under chapter 62C or 62D that contracts with a managed care plan or county-based purchasing plan to provide covered dental care services to enrollees of the plan.

Subd. 6g. **Uniform dental credentialing process.** (a) By January 1, 2022, the managed care plans, county-based purchasing plans, and dental benefit administrators that contract with the commissioner or

subcontract with plans to provide dental services to medical assistance or MinnesotaCare enrollees shall develop a uniform credentialing process for dental providers.

(b) The process developed in this subdivision must include a uniform credentialing application that must be available in electronic format and accessible on each plan or dental benefits administrator's website. The process developed under this subdivision must include an option to electronically submit a completed application. The uniform credentialing application must be available for free to providers.

(c) If applicable, a managed care plan, county-based purchasing plan, dental benefits administrator, contractor, or vendor that reviews and approves a credentialing application must notify a provider regarding a deficiency on a submitted credentialing application form no later than 30 business days after receiving the application form from the provider.

(d) For purposes of this subdivision, "dental benefits administrator" means an organization, including an organization licensed under chapter 62C or 62D, that contracts with a managed care plan or county-based purchasing plan to provide covered dental care services to enrollees of the plan.

(e) This subdivision must be in compliance with the federal requirements for Medicaid and Basic Health Program provider enrollment.

Subd. 6h. **Continuity of care for seniors receiving personal assistance.** (a) If an individual 65 years of age or older is receiving personal assistance from the same agency continuously during the six months prior to being newly enrolled with any managed care or county-based purchasing plan, the managed care or county-based purchasing plan with which the individual is newly enrolled must offer the agency a contract for the purposes of allowing the enrollee to receive any personal assistance covered under the terms of the plan from the enrollee's current agency, provided the enrollee continues to live in the service area of the enrollee's current agency.

(b) For the purposes of this subdivision, the following terms have the meanings given:

(1) "agency" means any of the following:

(i) a personal care assistance provider agency as defined under section 256B.0659, subdivision 1, paragraph (l);

(ii) an agency provider as described in section 256B.8502, subdivision 4; or

(iii) a financial management services provider for an enrollee who directly employs direct care staff through the community first services and supports budget model or through the consumer-directed community supports option available under the elderly waiver; and

(2) "personal assistance" means any of the following:

(i) personal care assistance services, extended personal care assistance services, or enhanced rate personal care assistance services under section 256B.0659;

(ii) community first services and supports, extended community first services and supports, or enhanced rate community first services and supports under section 256B.85; or

(iii) personal assistance provided through the consumer-directed community supports option available under the elderly waiver.

(c) This subdivision applies only if the enrollee's current agency agrees to accept as payment in full the managed care plan's or county-based purchasing plan's in-network reimbursement rate for the same covered service at the time the service is provided, and agrees to enter into a managed care plan's or county-based purchasing plan's contract for services of like kind.

Subd. 6i. **Directed pharmacy dispensing payment.** (a) The commissioner shall provide a directed pharmacy dispensing payment of $4.50 per filled prescription to eligible outpatient retail pharmacies in Minnesota to improve and maintain access to pharmaceutical services in rural and underserved areas of Minnesota. Managed care and county-based purchasing plans delivering services under section 256B.69 or 256B.692, and any pharmacy benefit managers under contract with these entities, must pay the directed pharmacy dispensing payment to eligible outpatient retail pharmacies for drugs dispensed to medical assistance enrollees. The directed pharmacy dispensing payment is in addition to, and must not supplant or reduce, any other dispensing fee paid by these entities to the pharmacy. Entities paying the directed pharmacy dispensing payment must not reduce other payments to the pharmacy as a result of payment of the directed pharmacy dispensing payment.

(b) For purposes of this subdivision, "eligible outpatient retail pharmacy" means an outpatient retail pharmacy licensed under chapter 151 that is not owned, either directly or indirectly or through an affiliate or subsidiary, by a pharmacy benefit manager licensed under chapter 62W or a health carrier, as defined in section 62A.011, subdivision 2, and that:

(1) is located in a medically underserved area or primarily serves a medically underserved population, as defined by the United States Department of Health and Human Services Health Resources and Services Administration under United States Code, title 42, section 254; or

(2) shares common ownership with 13 or fewer Minnesota pharmacies.

(c) In order to receive the directed pharmacy dispensing payment, a pharmacy must submit to the commissioner a form, developed by the commissioner, attesting that the pharmacy meets the requirements of paragraph (b).

(d) Managed care and county-based purchasing plans, and any pharmacy benefit managers under contract with these entities, shall pay the directed pharmacy dispensing payment to eligible outpatient retail pharmacies. The commissioner shall monitor the effect of this requirement on access to pharmaceutical services in rural and underserved areas of Minnesota. If, for any contract year, federal approval is not received for this subdivision, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect removal of this subdivision. Contracts between managed care plans and county-based purchasing plans, and any pharmacy benefit managers under contract with these entities, and providers to whom this subdivision applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this subdivision. This subdivision expires if federal approval is not received for this subdivision at any time.

(e) This subdivision expires on December 31, 2026.

[See Note.]

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. MS 2010 [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 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, including Minnesota Supplement Report #1A;

(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;

(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.

(d) Managed care plans and county-based purchasing plans shall certify to the commissioner for the purpose of financial reporting for state public health care programs under this subdivision that costs reported for state public health care programs include:

(1) only services covered under the state plan and waivers, and related allowable administrative expenses; and

(2) the dollar value of unallowable and nonstate plan services, including both medical and administrative expenditures, that have been excluded.

Subd. 9d. **Financial and quality assurance audits.** (a) 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 audits by the legislative auditor under subdivision 9e 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, the legislative auditor, and vendors contracting with the legislative auditor, access to all data required to complete audits under subdivision 9e.

(b) 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.

(c) Upon completion of the evaluation under paragraph (b), the commissioner shall provide copies of the report to the legislative auditor.

(d) 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.

(e) The commissioner, to the extent of available funding, shall conduct ad hoc audits of state public health care program administrative and medical expenses reported by managed care plans and county-based purchasing plans. This includes: financial and encounter data reported to the commissioner under subdivision 9c, including payments to providers and subcontractors; supporting documentation for expenditures; categorization of administrative and medical expenses; and allocation methods used to attribute administrative expenses to state public health care programs. These audits also must monitor compliance with data and financial report certification requirements established by the commissioner for the purposes of managed care capitation payment rate-setting. The managed care plans and county-based purchasing plans shall fully cooperate with the audits in this subdivision.

(f) Nothing in this subdivision shall allow the release of information that is nonpublic data pursuant to section 13.02.

Subd. 9e. **Financial audits.** The legislative auditor shall audit managed care plans and county-based purchasing plans to determine if a managed care plan or county-based purchasing plan used public money in compliance with federal and state laws, rules, and in accordance with provisions in the plan's contract with the commissioner. The legislative auditor shall conduct the audits in accordance with section 3.972, subdivision 2b.

Subd. 9f. **Annual report on provider reimbursement rates.** (a) The commissioner, by December 15 of each year, shall submit to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance a report on managed care and county-based purchasing plan provider reimbursement rates.

(b) The report must include, for each managed care and county-based purchasing plan, the mean and median provider reimbursement rates by county for the calendar year preceding the reporting year, for the five most common billing codes statewide across all plans, in each of the following provider service categories if within the county there are more than three medical assistance enrolled providers providing the specific service within the specific category:

(1) physician prenatal services;

(2) physician preventive services;

(3) physician services other than prenatal or preventive;

(4) dental services;

(5) inpatient hospital services;

(6) outpatient hospital services;

(7) mental health services; and

(8) substance use disorder services.

(c) The commissioner shall also include in the report:

(1) the mean and median reimbursement rates across all plans by county for the calendar year preceding the reporting year for the billing codes and provider service categories described in paragraph (b); and

(2) the mean and median fee-for-service reimbursement rates by county for the calendar year preceding the reporting year for the billing codes and provider service categories described in paragraph (b).

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. 10a. **Data sharing for program integrity.** If the commissioner receives a written report from a managed care plan that has reason to believe that a provider, vendor, managed care employee, subcontractor, or enrollee committed fraud under this chapter or chapter 256L, the commissioner must provide summary data, as defined in section 13.02, subdivision 19, from the report to other managed care plans contracted under this section within ten days of receiving the report. Nothing in this subdivision allows release of information that is nonpublic data pursuant to section 13.02, subdivision 9.

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. MS 1988 [Repealed, 1989 c 282 art 3 s 98]

Subd. 13. MS 1988 [Repealed, 1989 c 282 art 3 s 98]

Subd. 14. MS 1988 [Repealed, 1989 c 282 art 3 s 98]

Subd. 15. MS 1988 [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, 9500.1462, 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.

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. 19a. **Limitation on reimbursement; rare disease services provided in Minnesota by out-of-network providers.** (a) If a managed care or county-based purchasing plan has an established contractual payment under medical assistance with an out-of-network provider for a service provided in Minnesota related to the diagnosis, monitoring, and treatment of a rare disease or condition, the provider must accept the established contractual payment for that service as payment in full.

(b) If a plan does not have an established contractual payment under medical assistance with an out-of-network provider for a service provided in Minnesota related to the diagnosis, monitoring, and treatment of a rare disease or condition, the provider must accept the provider's established rate for uninsured patients for that service as payment in full. If the provider does not have an established rate for uninsured patients for that service, the provider must accept the fee-for-service rate.

Subd. 19b. **Limitation on reimbursement; rare disease services provided outside of Minnesota by an out-of-network provider.** (a) If a managed care or county-based purchasing plan has an established contractual payment under medical assistance with an out-of-network provider for a service provided in another state related to diagnosis, monitoring, and treatment of a rare disease or condition, the plan must pay the established contractual payment for that service.

(b) If a plan does not have an established contractual payment under medical assistance with an out-of-network provider for a service provided in another state related to diagnosis, monitoring, and treatment of a rare disease or condition, the plan must pay the provider's established rate for uninsured patients for that service. If the provider does not have an established rate for uninsured patients for that service, the plan must pay the provider the fee-for-service rate in that state.

Subd. 20. MS 2020 [Repealed, 2022 c 98 art 2 s 16]

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 ombudsperson established in section 256B.6903.

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 persons and persons with a disability.** (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 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 persons with a disability, or persons with a disability only. For persons with a primary diagnosis of developmental disability, serious and persistent mental illness, or serious mental illness in children, 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 mental illness in children without approval of the county board of the county in which the demonstration is being implemented.

(b) MS 2009 Supp [Expired, 2003 c 47 s 4; 2007 c 147 art 7 s 60]

(c) Before implementation of a demonstration project for persons with a disability, 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 access for disability inclusion 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.

(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 access for disability inclusion 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. MS 1988 [Repealed, 1999 c 245 art 3 s 51]

Subd. 24a. MS 2012 [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 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;

(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 website 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.

(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

(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. 31a. MS 2024 [Repealed, 2026 c 127 art 14 s 8]

Subd. 32. MS 2014 [Repealed, 2015 c 71 art 11 s 65]

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 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 website 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 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.

Subd. 36. **Enrollee support system.** (a) The commissioner shall establish an enrollee support system that provides support to an enrollee before and during enrollment in a managed care plan.

(b) The enrollee support system must:

(1) provide access to counseling for each potential enrollee on choosing a managed care plan;

(2) assist an enrollee in understanding enrollment in a managed care plan;

(3) provide an access point for complaints regarding enrollment, covered services, and other related matters;

(4) provide information on an enrollee's grievance and appeal rights within the managed care organization and the state's fair hearing process, including an enrollee's rights and responsibilities; and

(5) provide assistance to an enrollee, upon request, in navigating the grievance and appeals process within the managed care organization and in appealing adverse benefit determinations made by the managed care organization to the state's fair hearing process after the managed care organization's internal appeals process has been exhausted. Assistance does not include providing representation to an enrollee at the state's fair hearing, but may include a referral to appropriate legal representation sources.

(c) Outreach to enrollees through the support system must be accessible to an enrollee through multiple formats, including telephone, Internet, in-person, and, if requested, through auxiliary aids and services.

(d) The commissioner may designate enrollment brokers to assist enrollees on selecting a managed care organization and providing necessary enrollment information. For purposes of this subdivision, "enrollment broker" means an individual or entity that performs choice counseling or enrollment activities in accordance with Code of Federal Regulations, part 42, section 438.810, or both.

Subd. 37. **Networks.** (a) The commissioner shall ensure that a managed care organization's network providers are enrolled with the commissioner as medical assistance providers, and that the providers comply with the provider disclosure, screening, and enrollment requirements in Code of Federal Regulations, part 42, section 455. A provider that has a network provider contract with the managed care organization is not required to provide services to a medical assistance or MinnesotaCare recipient who is receiving services through the fee-for-service system.

(b) A managed care organization may enter into a network provider contract with a provider that is not a medical assistance provider for a period of up to 120 days pending the outcome of the medical assistance provider enrollment process. A managed care organization must terminate the contract upon notification

that the provider cannot be enrolled as a medical assistance provider or upon expiration of the 120-day period if notification has not been received within that period. The managed care organization must notify each affected enrollee of the provider contract termination.

(c) For purposes of this subdivision, "network provider" means any provider, group of providers, entity with a network provider agreement with the managed care organization, or subcontractor that receives payments from the managed care organization either directly or indirectly to provide services under a managed care contract between the commissioner and the managed care organization.

(d) A managed care organization is not required to include a provider in its network before approving the provider's credentials in accordance with section 62Q.097.

Subd. 38. **Duties when a provider is no longer able to provide services.** When a provider is subject to a serious operational event or administrative action under section 256B.045, managed care and county-based purchasing plans must:

(1) follow the continuity of care planning and complex transition planning requirements under sections 256B.045 and 256B.046;

(2) honor existing services authorizations when clinically appropriate for continuity and safe transfer of services; and

(3) ensure timely contracting or single-case arrangements to prevent services gaps.

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; 2015 c 71 art 11 s 33-37; 2015 c 78 art 6 s 31; 2016 c 158 art 1 s 131; 2017 c 40 art 1 s 121; 1Sp2017 c 6 art 4 s 48; art 15 s 2,3; 2018 c 182 art 1 s 52; 2019 c 54 art 2 s 38; 1Sp2019 c 9 art 7 s 34,35; 2020 c 115 art 3 s 31; 2021 c 30 art 13 s 57; 1Sp2021 c 7 art 1 s 18-20; art 13 s 48; 2022 c 55 art 1 s 136,137; 2022 c 98 art 2 s 11; art 14 s 24; 2023 c 57 art 2 s 62; 2023 c 70 art 1 s 30-32; 2024 c 80 art 6 s 4; 2024 c 108 art 3 s 4; art 6 s 4; 2024 c 115 art 16 s 43; 2024 c 125 art 3 s 13; 2024 c 127 art 48 s 13; art 57 s 66; 2025 c 38 art 8 s 68; 1Sp2025 c 3 art 4 s 7,8; art 8 s 24; 1Sp2025 c 9 art 9 s 6; 2026 c 88 art 1 s 132; 2026 c 121 art 1 s 4; art 3 s 59-61; art 9 s 61; 2026 c 127 art 5 s 10*

NOTE: The amendments to subdivision 4 by Laws 2024, chapter 125, article 3, section 13; and Laws 2024, chapter 127, article 48, section 13, are effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2024, chapter 125, article 3, section 13; and Laws 2024, chapter 127, article 48, section 13, the effective dates.

NOTE: Subdivision 6i, as added by Laws 2025, First Special Session chapter 3, article 4, section 8, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2025, First Special Session chapter 3, article 4, section 8, the effective date.

256B.6903 OMBUDSPERSON FOR MANAGED CARE.

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

(b) "Adverse benefit determination" has the meaning provided in Code of Federal Regulations, title 42, section 438.400, subpart (b).

(c) "Appeal" means an oral or written request from an enrollee to the managed care organization for review of an adverse benefit determination.

(d) "Commissioner" means the commissioner of human services.

(e) "Complaint" means an enrollee's informal expression of dissatisfaction about any matter relating to the enrollee's prepaid health plan other than an adverse benefit determination.

(f) "Data analyst" means the person employed by the ombudsperson that uses research methodologies to conduct research on data collected from prepaid health plans, including but not limited to scientific theory; hypothesis testing; survey research techniques; data collection; data manipulation; and statistical analysis interpretation, including multiple regression techniques.

(g) "Enrollee" means a person enrolled in a prepaid health plan under section 256B.69. When applicable, an enrollee includes an enrollee's authorized representative.

(h) "External review" means the process described under Code of Federal Regulations, title 42, section 438.408, subpart (f); and section 62Q.73, subdivision 2.

(i) "Grievance" means an enrollee's expression of dissatisfaction about any matter relating to the enrollee's prepaid health plan other than an adverse benefit determination that follows the procedures outlined in Code of Federal Regulations, title 42, part 438, subpart (f). A grievance may include but is not limited to concerns relating to quality of care, services provided, or failure to respect an enrollee's rights under a prepaid health plan.

(j) "Managed care advocate" means a county or Tribal employee who works with managed care enrollees when the enrollee has service, billing, or access problems with the enrollee's prepaid health plan.

(k) "Prepaid health plan" means a plan under contract with the commissioner according to section 256B.69.

(l) "State fair hearing" means the appeals process mandated under section 256.045, subdivision 3a.

Subd. 2. **Ombudsperson.** The commissioner must designate an ombudsperson to advocate for enrollees. At the time of enrollment in a prepaid health plan, the local agency must inform enrollees about the ombudsperson.

Subd. 3. **Duties and cost.** (a) The ombudsperson must work to ensure enrollees receive covered services as described in the enrollee's prepaid health plan by:

(1) providing assistance and education to enrollees, when requested, regarding covered health care benefits or services; billing and access; or the grievance, appeal, or state fair hearing processes;

(2) with the enrollee's permission and within the ombudsperson's discretion, using an informal review process to assist an enrollee with a resolution involving the enrollee's prepaid health plan's benefits;

(3) assisting enrollees, when requested, with prepaid health plan grievances, appeals, or the state fair hearing process;

(4) overseeing, reviewing, and approving documents used by enrollees relating to prepaid health plans' grievances, appeals, and state fair hearings;

(5) reviewing all state fair hearings and requests by enrollees for external review; overseeing entities under contract to provide external reviews, processes, and payments for services; and utilizing aggregated results of external reviews to recommend health care benefits policy changes; and

(6) providing trainings to managed care advocates.

(b) The ombudsperson must not charge an enrollee for the ombudsperson's services.

Subd. 4. **Powers.** In exercising the ombudsperson's authority under this section, the ombudsperson may:

(1) gather information and evaluate any practice, policy, procedure, or action by a prepaid health plan, state human services agency, county, or Tribe; and

(2) prescribe the methods by which complaints are to be made, received, and acted upon. The ombudsperson's authority under this clause includes but is not limited to:

(i) determining the scope and manner of a complaint;

(ii) holding a prepaid health plan accountable to address a complaint in a timely manner as outlined in state and federal laws;

(iii) requiring a prepaid health plan to respond in a timely manner to a request for data, case details, and other information as needed to help resolve a complaint or to improve a prepaid health plan's policy; and

(iv) making recommendations for policy, administrative, or legislative changes regarding prepaid health plans to the proper partners.

Subd. 5. **Data.** (a) The data analyst must review and analyze prepaid health plan data on denial, termination, and reduction notices (DTRs), grievances, appeals, and state fair hearings by:

(1) analyzing, reviewing, and reporting on DTRs; grievances; appeals; and state fair hearings data collected from each prepaid health plan;

(2) collaborating with the commissioner's partners and the Department of Health for the Triennial Compliance Assessment under Code of Federal Regulations, title 42, section 438.358, subpart (b);

(3) reviewing state fair hearing decisions for policy or coverage issues that may affect enrollees; and

(4) providing data required under Code of Federal Regulations, title 42, section 438.66 (2016), to the Centers for Medicare and Medicaid Services.

(b) The data analyst must share the data analyst's data observations and trends under this subdivision with the ombudsperson, prepaid health plans, and commissioner's partners.

Subd. 6. **Collaboration and independence.** (a) The ombudsperson must work in collaboration with the commissioner and the commissioner's partners when the ombudsperson's collaboration does not otherwise interfere with the ombudsperson's duties under this section.

(b) The ombudsperson may act independently of the commissioner when:

(1) providing information or testimony to the legislature; and

(2) contacting and making reports to federal and state officials.

Subd. 7. **Civil actions.** The ombudsperson is not civilly liable for actions taken under this section if the action was taken in good faith, was within the scope of the ombudsperson's authority, and did not constitute willful or reckless misconduct.

History: *2022 c 98 art 2 s 12*

256B.691 RISK-BASED TRANSPORTATION PAYMENTS.

Any contract with a prepaid health plan under the medical assistance 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; 2016 c 158 art 2 s 99*

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; all applicable provisions of chapter 62Q, including sections 62D.081; 62Q.1055; 62Q.106; 62Q.12; 62Q.135; 62Q.14; 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, 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 $30,000, 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;

(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:

(i) substantially fails to meet the requirements of this section, or

(ii) the commissioner determines would substantially impair the state's ability to purchase health care services in other areas of the state, or

(iii) would substantially impair an enrollee's choice of care systems when reasonable choice is possible, or

(iv) 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. MS 2012 [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; 2017 c 40 art 1 s 78; 2020 c 114 art 2 s 19; 2023 c 70 art 4 s 78; 1Sp2025 c 3 art 1 s 87; 2026 c 127 art 1 s 43

256B.6925 ENROLLEE INFORMATION.

Subdivision 1. **Information provided by commissioner.** The commissioner shall provide to each potential enrollee the following information:

(1) basic features of receiving services through managed care;

(2) which individuals are excluded from managed care enrollment, subject to mandatory managed care enrollment, or who may choose to enroll voluntarily;

(3) for mandatory and voluntary enrollment, the length of the enrollment period and information about an enrollee's right to disenroll in accordance with Code of Federal Regulations, part 42, section 438.56;

(4) the service area covered by each managed care organization;

(5) covered services, including services provided by the managed care organization and services provided by the commissioner;

(6) the provider directory and drug formulary for each managed care organization;

(7) cost-sharing requirements;

(8) requirements for adequate access to services, including provider network adequacy standards;

(9) a managed care organization's responsibility for coordination of enrollee care; and

(10) quality and performance indicators, including enrollee satisfaction for each managed care organization, if available.

Subd. 2. **Information provided by managed care organization.** The commissioner shall ensure that managed care organizations provide to each enrollee the following information:

(1) an enrollee handbook within a reasonable time after receiving notice of the enrollee's enrollment. The handbook must, at a minimum, include information on benefits provided, how and where to access benefits, cost-sharing requirements, how transportation is provided, and other information as required by Code of Federal Regulations, part 42, section 438.10, paragraph (g);

(2) a provider directory for the following provider types: physicians, specialists, hospitals, pharmacies, behavioral health providers, and long-term supports and services providers, as appropriate. The directory must include the provider's name, group affiliation, street address, telephone number, website, specialty if applicable, whether the provider accepts new enrollees, the provider's cultural and linguistic capabilities as identified in Code of Federal Regulations, part 42, section 438.10, paragraph (h), and whether the provider's office accommodates people with disabilities;

(3) a drug formulary that includes both generic and name brand medications that are covered and each medication tier, if applicable;

(4) written notice of termination of a contracted provider. Within 15 calendar days after receipt or issuance of the termination notice, the managed care organization must make a good faith effort to provide notice to each enrollee who received primary care from, or was seen on a regular basis by, the terminated provider; and

(5) upon enrollee request, the managed care organization's physician incentive plan.

Subd. 3. **Provision of information.** (a) All information required to be provided to enrollees and potential enrollees of a managed care organization, including the provider directory, enrollee handbook, and drug formulary, must be provided in a manner and format that is easily understood and readily accessible. The information must be available through the enrollee support system established under section 256B.69, subdivision 36, the department's website and each managed care organization's website. The commissioner and managed care organization shall inform each enrollee that the information is available on the department's and the managed care organization's websites and shall provide the potential enrollee or enrollee with the applicable URL to access the information. An enrollee with a disability who cannot access the information online must be provided, upon request, with auxiliary aids and services necessary to access the information at no cost to the enrollee.

(b) The commissioner and managed care organization shall provide all required information electronically to potential enrollees and enrollees unless the enrollee requests the information in paper form. The commissioner and managed care organization shall inform an enrollee that, upon request, the information is available in paper form without charge to the enrollee, and shall mail the information to the potential enrollee's or the enrollee's mailing address within five business days of the request. If the information is provided to the enrollee through email, the managed care organization must receive the enrollee's agreement before providing the information by email.

(c) The information required to be provided electronically to a potential enrollee or enrollee must:

(1) be readily accessible;

(2) be published in a prominent location on the commissioner's and managed care organization's websites in a format that has the capability of being retained and printed; and

(3) satisfy the requirements for content and language requirements in accordance with Code of Federal Regulations, part 42, section 438.10, paragraph (d).

Subd. 4. **Language and accessibility standards.** (a) Managed care contracts entered into under section 256B.69, 256B.692, or 256L.12, must require a managed care organization to provide language assistance, and auxiliary aids and services, if requested, to ensure access to a managed care organization's programs and services, as required under United States Code, title 42, sections 18116 and 2000d, and any other federal regulations or guidance from the United States Department of Health and Human Services.

(b) The commissioner shall establish a methodology to identify the prevalent non-English languages spoken by enrollees and potential enrollees throughout Minnesota and in each managed care organization's service area.

(c) The commissioner shall ensure that oral interpretation is provided in all languages and written interpretation is provided in each prevalent non-English language, and that both are available to enrollees and potential enrollees free of charge. Oral interpretation services shall include the use of auxiliary aids, TTY/TDY, and American sign language.

(d) All written materials that target potential enrollees and are provided to enrollees, including the provider directory, enrollee handbook, appeals and grievance notices, and denial and termination notices, must:

(1) use at least 12-point font;

(2) be written at a 7th grade reading level;

(3) be available in alternative formats and through auxiliary aids and services that consider the special needs of the enrollee, including an enrollee with a disability or limited English proficiency;

(4) use taglines that consist of short statements in each of the prevalent non-English languages, in an 18-point font, that explain the availability of language interpreter services free of charge; and

(5) explain how to request auxiliary aids and services, including the provision of the materials in alternative formats and the TTY/TDY telephone number of the managed care organization's customer service unit and the department's enrollee support system.

(e) For purposes of this subdivision, "prevalent non-English language" means a non-English language that is determined by the commissioner to be spoken by a significant number or percentage of potential enrollees and enrollees with limited proficiency in English.

Subd. 5. **Enrollee communication.** (a) The commissioner shall ensure that the managed care organization:

(1) submits all marketing materials to the commissioner for approval before distribution and that marketing materials are accurate and do not mislead, confuse, or defraud;

(2) distributes marketing materials to a managed care organization's entire service area and as otherwise permitted by contract;

(3) complies with the information requirements in Code of Federal Regulations, part 42, section 438.10;

(4) does not seek to influence enrollment with the sale or offering of any private insurance, with the exception of communications between an enrollee and a managed care organization that is related to the offering of a qualified health plan as defined under section 62K.03; and

(5) does not directly, or indirectly, engage in door-to-door, telephone, email, texting, or other cold-call marketing activities.

(b) For the purposes of this subdivision, "cold-call marketing activities" means any unsolicited personal contact or communication by a managed care organization with an individual who is not enrolled in that managed care organization that can be reasonably interpreted as intended to influence the individual to enroll in a specific managed care organization or to not enroll in or disenroll from another managed care organization.

History: *1Sp2017 c 6 art 15 s 4*

256B.6926 STATE MONITORING.

Subdivision 1. **Generally.** (a) The commissioner shall establish a monitoring system that addresses all aspects of the managed care program, including the performance of each managed care organization in the areas identified under Code of Federal Regulations, part 42, section 438.66, paragraph (b).

(b) The commissioner shall use data collected from the monitoring activities, including, at a minimum, the data identified in Code of Federal Regulations, part 42, section 438.66, paragraph (c), to improve the performance of the managed care program.

Subd. 2. **Readiness review.** The commissioner shall conduct a readiness review of each managed care organization that contracts with the commissioner to assess the managed care organization's ability and capacity to perform satisfactorily in the areas described in Code of Federal Regulations, part 42, section 438.66, paragraph (d), clauses (1) to (4). The review must be conducted and approval must be received from

the Centers for Medicare and Medicaid Services prior to the commissioner entering into a contract with the managed care organization.

Subd. 3. **Report.** (a) The commissioner shall submit to the Centers for Medicare and Medicaid Services, no later than 180 days after each contract year, a report on the managed care program administered by the commissioner, regardless of the authority under which the program operates, with the initial report being submitted 180 days after the contract year following the release of the Centers for Medicare and Medicaid Services guidance. Each report must, at a minimum, assess the managed care program's operation in the areas identified in Code of Federal Regulations, part 42, section 438.66, paragraph (e), clause (2), and must be:

(1) provided to the Medicaid Citizens' Advisory Committee as required under Code of Federal Regulations, part 42, section 431.12;

(2) provided to the stakeholder consultation group as required under Code of Federal Regulations, part 42, section 438.70, to the extent the managed care program includes long-term services and supports; and

(3) published on the department's website.

(b) The report described under this subdivision may be used to meet the commissioner's reporting obligation under the managed care waiver authority for the managed care program.

Subd. 4. **Conflicts of interest.** The commissioner shall implement safeguards against conflicts of interest on behalf of state and local officers and employees and agents of the state who have responsibilities relating to managed care contracts. The safeguards must be at least as effective as the safeguards specified in United States Code, title 41, sections 2101 to 2107. The commissioner shall comply with Code of Federal Regulations, part 42, section 438.58, and United States Code, title 42, section 1396a, paragraph (a), clause (4), item (c), applicable to contracting officers, employees, or independent contractors.

History: *1Sp2017 c 6 art 15 s 5*

256B.6927 QUALITY ASSESSMENT AND PERFORMANCE.

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

(b) "Access" means the availability and timely use of services to achieve optimal outcomes as required under Code of Federal Regulations, part 42, sections 438.68 and 438.206.

(c) "External quality review" means the analysis and evaluation by an external quality review organization of the aggregated information on quality, timeliness, and access to the health care services that a managed care organization or the managed care organization's contractor provides to enrollees.

(d) "External quality review organization" means an organization that meets the competence and independence requirements under Code of Federal Regulations, part 42, section 438.354, and performs external quality review and may perform other external quality review-related activities as required under Code of Federal Regulations, part 42, section 438.358.

(e) "Quality" means the degree that a managed care organization increases the likelihood of desired outcomes of a managed care organization's enrollees through:

(1) a managed care organization's structural and operational characteristics;

(2) the provision of services that are consistent with current professional, evidence-based knowledge; and

(3) interventions for performance improvement.

(f) "Validation" means the review of information, data, and procedures to determine the extent that information, data, and procedures are accurate, reliable, free from bias, and according to standards for data collection and analysis.

Subd. 2. **Quality strategy.** (a) The commissioner shall implement a written quality strategy for assessing and improving the quality of health care and other services provided by managed care organizations. At a minimum, the quality strategy must include:

(1) defined network adequacy requirements and availability of services standards for managed care organizations, including examples of evidence-based clinical practice guidelines;

(2) measurable goals and objectives for continuous quality improvement that consider the health status of all populations served by the managed care organization;

(3) a description of:

(i) the quality metrics and performance targets used in measuring the performance and improvement of each managed care organization; and

(ii) performance improvement projects, including a description of any intervention proposed by the commissioner to improve access, quality, or timeliness of care for enrollees;

(4) annual, external independent reviews of quality outcomes, and the timeliness of and access to services covered by the managed care organization;

(5) a description of the managed care organization's transition of care policy;

(6) a plan to identify, evaluate, and reduce health disparities based on an enrollee's age, race, ethnicity, sex, primary language, or disability status, and provide this demographic information to the managed care organization at the time of enrollment;

(7) appropriate use of intermediate sanctions to be imposed on a managed care organization;

(8) the mechanisms implemented to identify enrollees who need long-term services and supports or enrollees with special health care needs; and

(9) information related to nonduplication of the external quality review activities in accordance with Code of Federal Regulations, part 42, section 438.360, paragraph (c).

(b) In developing the initial quality strategy, the commissioner shall:

(1) obtain input from the Medicaid Citizens' Advisory Committee, enrollees, and other interested stakeholders;

(2) consult with the Tribes according to the Tribal consultation policy;

(3) consider recommendations from the external quality review organization identified under subdivision 3, for improving the quality of health care services furnished by the managed care organization; and

(4) make the strategy available for public comment.

(c) The commissioner shall submit a copy of the initial quality strategy to the Centers for Medicare and Medicaid Services for comments and feedback. If significant changes are made based on the comments and feedback received, the commissioner shall publish the revised quality strategy on the department's website. The commissioner shall make the final quality strategy available on the department's website.

(d) The commissioner shall review and update the quality strategy at least every three years or more frequently, if needed. The review shall include an evaluation of the effectiveness of the quality strategy conducted within the previous three years. The results of the review and any updates shall be published on the department's website.

Subd. 3. **External quality reviews.** (a) The commissioner shall contract with an external quality review organization in accordance with Code of Federal Regulations, part 42, section 438.354, to conduct an annual external quality review of each managed care organization. The commissioner shall ensure that all necessary information is provided to the external quality review organization for analysis and inclusion in the external quality review technical report required under paragraph (g). The information provided must be obtained in accordance with Code of Federal Regulations, part 42, section 438.352.

(b) The commissioner shall follow an open, competitive procurement process according to state and federal law for any contract with an external quality review organization. The external quality review organization may use a subcontractor if the subcontractor meets the requirements for independence. The external quality review organization is accountable for and must oversee all functions performed by the subcontractor.

(c) The following mandatory external quality review related activities must be performed for each managed care organization:

(1) validation of performance improvement projects, performance measures, and meeting network adequacy requirements for the 12 months preceding the most recently completed contract period; and

(2) review of the managed care organization's compliance with Code of Federal Regulations, part 42, subpart D, and section 438.330 for the preceding three years.

(d) The commissioner may elect to incorporate any of the optional activities listed in Code of Federal Regulations, part 42, section 438.358, paragraph (c), as part of the external quality review.

(e) To avoid duplication, the commissioner may use information from a Medicare or private accreditation review to provide information for a managed care organization's annual external quality review instead of conducting one or more of the mandatory external quality review activities. The information used must satisfy Code of Federal Regulations, part 42, section 438.360, paragraph (a).

(f) If the conditions in Code of Federal Regulations, part 42, section 438.362, are satisfied, the commissioner may accept the data, correspondence, information, and findings regarding the managed care organization's compliance with a Medicare quality review in lieu of performing an external quality review. For each managed care organization exempt from an external quality review, the commissioner shall obtain the most recent Medicare review findings or Medicare information from a private national accrediting organization that the Centers for Medicare and Medicaid Services approves and recognizes for Medicare Advantage Organization deeming.

(g) The qualified external quality review organization must produce an annual external quality review technical report in accordance with Code of Federal Regulations, part 42, section 438.364. The technical report must summarize findings on access and quality of care. The commissioner may revise the final external quality review technical report if there is evidence of error or omission. The final external quality review

technical report must be published on the department's website by April 30 of each year and copies of the report must be made available upon request and in alternative formats. Information in the technical report must not disclose the identity or other protected patient identifying health information.

History: *1Sp2017 c 6 art 15 s 6*

256B.6928 MANAGED CARE RATES AND PAYMENTS.

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

(b) "Base amount" has the meaning given in Code of Federal Regulations, part 42, section 438.6, paragraph (a).

(c) "Budget neutral" has the meaning given in Code of Federal Regulations, part 42, section 438.5, paragraph (a).

(d) "Credibility adjustment" has the meaning given in Code of Federal Regulations, part 42, section 438.8, paragraph (b).

(e) "Full credibility" has the meaning given in Code of Federal Regulations, part 42, section 438.8, paragraph (b).

(f) "Incentive arrangement" has the meaning given in Code of Federal Regulations, part 42, section 438.6.

(g) "Medical loss ratio" has the meaning given in Code of Federal Regulations, part 42, section 438.8, paragraph (b).

(h) "Medical loss ratio reporting year" has the meaning given in Code of Federal Regulations, part 42, section 438.8, paragraph (b).

(i) "Member months" has the meaning given in Code of Federal Regulations, part 42, section 438.8, paragraph (b).

(j) "No credibility" has the meaning given in Code of Federal Regulations, part 42, section 438.8, paragraph (b).

(k) "Partial credibility" has the meaning given in Code of Federal Regulations, part 42, section 438.8, paragraph (b).

(l) "Pass-through payment" has the meaning given in Code of Federal Regulations, part 42, section 438.6, paragraph (a).

(m) "Rate cell" has the meaning given in Code of Federal Regulations, part 42, section 438.2.

(n) "Risk adjustment" has the meaning given in Code of Federal Regulations, part 42, section 438.5, paragraph (a).

Subd. 2. **Actuarial soundness.** (a) Capitation rates for managed care organizations must be reviewed and approved by the Centers for Medicare and Medicaid Services as actuarially sound. The capitation rates must be provided in the format and time frame required by Code of Federal Regulations, part 42, section 438.7. Capitation rates must:

(1) be developed in accordance with the rates standards in Code of Federal Regulations, part 42, section 438.5, and generally accepted actuarial principles and practices. Any proposed differences in capitation rates between covered populations must be based on valid rate development standards and not on the rate of federal financial participation associated with the covered populations;

(2) be appropriate for the populations covered and the services furnished under the contract;

(3) meet the requirements for availability of services, adequate capacity, and coordination and continuity of care in accordance with Code of Federal Regulations, part 42, sections 438.206, 438.207, and 438.208;

(4) be specific to each rate cell under the contract, and must not cross-subsidize or be cross-subsidized by payments from any other rate cell;

(5) meet any special contract provisions in accordance with Code of Federal Regulations, part 42, section 438.6; and

(6) be developed to reasonably achieve a medical loss ratio standard of at least 85 percent for the rate year, or a higher minimum medical loss ratio if mandated by the commissioner, as long as the capitation rates are adequate for reasonable, appropriate, and attainable nonbenefit costs.

(b) An independent actuary must certify that the rates were developed in accordance with Code of Federal Regulations, part 42, section 438.3, paragraph (c), clause (1), item (ii), paragraph (e).

Subd. 3. **Rate development standards.** (a) In developing capitation rates, the commissioner shall:

(1) identify and develop base utilization and price data, including validated encounter data and audited financial reports received from the managed care organizations that demonstrate experience for the populations served by the managed care organizations, for the three most recent and complete years before the rating period;

(2) develop and apply reasonable trend factors, including cost and utilization, to base data that are developed from actual experience of the medical assistance population or a similar population according to generally accepted actuarial practices and principles;

(3) develop the nonbenefit component of the rate to account for reasonable expenses related to the managed care organization's administration; taxes; licensing and regulatory fees; contribution to reserves; risk margin; cost of capital and other operational costs associated with the managed care organization's provision of covered services to enrollees;

(4) consider the value of cost-sharing for rate development purposes, regardless of whether the managed care organization imposes the cost-sharing on the enrollee or the cost-sharing is collected by the provider;

(5) make appropriate and reasonable adjustments to account for changes to the base data, programmatic changes, changes to nonbenefit components, and any other adjustment necessary to establish actuarially sound rates. Each adjustment must reasonably support the development of an accurate base data set for purposes of rate setting, reflect the health status of the enrolled population, and be developed in accordance with generally accepted actuarial principles and practices;

(6) consider the managed care organization's past medical loss ratio in the development of the capitation rates and consider the projected medical loss ratio; and

(7) select a prospective or retrospective risk adjustment methodology that must be developed in a budget-neutral manner consistent with generally accepted actuarial principles and practices.

(b) The base data must be derived from the medical assistance population or, if data on the medical assistance population is not available, derived from a similar population and adjusted to make the utilization and price data comparable to the medical assistance population. Data must be in accordance with actuarial standards for data quality and an explanation of why that specific data is used must be provided in the rate certification. If the commissioner is unable to base the rates on data that are within the three most recent and complete years before the rating period, the commissioner may request an approval from the Centers for Medicare and Medicaid Services for an exception. The request must describe why an exception is necessary and describe the actions that the commissioner intends to take to comply with the request.

Subd. 4. **Special contract requirements related to payment.** (a) If the commissioner uses risk-sharing mechanisms, including reinsurance, risk corridors, or stop-loss limits, the risk-sharing mechanism must be described in the contract, and must be developed according to the rate development standards and generally accepted actuarial principles and practices.

(b) The commissioner may utilize incentive payment arrangements in managed care organization contracts. Any incentive arrangement utilized by the commissioner must be made available to all managed care organizations under contract with the commissioner under the same terms of performance. The payment must not exceed 105 percent of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement and must be actuarially sound. For all incentive arrangements the contract must state that the arrangement is:

(1) for a fixed period of time and performance is measured during the rating period in which the incentive arrangement is applied;

(2) not renewed automatically; and

(3) associated with specified activities, targets, performance measures, or quality-based outcomes in the quality strategy described under section 256B.6927.

The incentive payment arrangement must not condition a managed care organization's participation in the incentive arrangement upon entering into or adhering to an intergovernmental transfer agreement.

(c) The commissioner may utilize withhold arrangements in managed care organization contracts. Any withhold arrangement utilized by the commissioner must be applied to all managed care organizations under contract with the commissioner under the same terms of performance. Any withhold arrangement must ensure that the capitation payment minus any portion of the withheld funds that is not reasonably achievable is actuarially sound. The total amount of the withheld funds, achievable or not, must be reasonable and must take into consideration each managed care organization's financial operating needs, accounting for the size and characteristics of the populations covered under the contract, as well as the managed care organization's capital reserves, as measured by the risk based capital level, months of claims reserve, or other appropriate measure of reserves. The data, assumptions, and methodologies used to determine the portion of the withhold that is reasonably achievable must be submitted as part of the documentation required by Code of Federal Regulations, part 42, section 438.7, paragraph (b), clause (6). For all withhold arrangements, the contract must state that the arrangement is:

(1) for a fixed period of time and performance is measured during the rating period in which the withhold arrangement is applied;

(2) not renewed automatically; and

(3) associated with specified activities, targets, performance measures, or quality-based outcomes in the state's quality strategy.

The withhold payment arrangement must not condition a managed care organization's participation in the withhold arrangement upon entering into or adhering to an intergovernmental transfer agreement.

Subd. 5. **Direction of managed care organization expenditures.** (a) The commissioner shall not direct managed care organizations expenditures under the managed care contract, except as permitted under Code of Federal Regulations, part 42, section 438.6(c). The exception under this paragraph includes the following situations:

(1) implementation of a value-based purchasing model for provider reimbursement, including pay-for-performance arrangements, bundled payments, or other service payments intended to recognize value or outcomes over volume of services;

(2) participation in a multipayer or medical assistance-specific delivery system reform or performance improvement initiative; or

(3) implementation of a minimum or maximum fee schedule, or a uniform dollar or percentage increase for network providers that provide a particular service. The maximum fee schedule must allow the managed care organization the ability to reasonably manage risk and provide discretion in accomplishing the goals of the contract.

(b) Any managed care contract that directs managed care organization expenditures as permitted under paragraph (a), clauses (1) to (3), must be developed in accordance with Code of Federal Regulations, part 42, sections 438.4 and 438.5; comply with actuarial soundness and generally accepted actuarial principles and practices; and have written approval from the Centers for Medicare and Medicaid Services before implementation. To obtain approval, the commissioner shall demonstrate in writing that the contract arrangement:

(1) is based on the utilization and delivery of services;

(2) directs expenditures equally, using the same terms of performance for a class of providers providing service under the contract;

(3) is intended to advance at least one of the goals and objectives in the commissioner's quality strategy;

(4) has an evaluation plan that measures the degree to which the arrangement advances at least one of the goals in the commissioner's quality strategy;

(5) does not condition network provider participation on the network provider entering into or adhering to an intergovernmental transfer agreement; and

(6) is not renewed automatically.

(c) For contract arrangements identified in paragraph (a), clauses (1) and (2), the commissioner shall:

(1) make participation in the value-based purchasing model, special delivery system reform, or performance improvement initiative available, using the same terms of performance, to a class of providers providing services under the contract related to the model, reform, or initiative; and

(2) use a common set of performance measures across all payers and providers.

(d) The commissioner shall not set the amount or frequency of the expenditures or recoup from the managed care organization any unspent funds allocated for these arrangements.

Subd. 6. **Monthly capitation payments for placements in institutions of mental disease.** The commissioner may make a monthly capitation payment to a managed care organization for an enrollee under the age of 65 receiving treatment for psychiatric or substance use disorder in an institution for mental diseases in accordance with Code of Federal Regulations, part 42, section 438.6, paragraph (e).

Subd. 7. **Rate certification submission.** (a) The commissioner shall submit the rate certifications to the Centers for Medicare and Medicaid Services for review and approval at the same time as the managed care contracts. The rate certification must satisfy Code of Federal Regulations, part 42, section 438.7, paragraph (b), and must include:

(1) base data used in the rate setting process;

(2) trend, including changes in the utilization and the price of services;

(3) the nonbenefit component of the rate;

(4) any adjustments;

(5) the prospective and retrospective risk adjustment methodology; and

(6) any special contract provisions related to payment.

(b) The commissioner, through the state's actuary, must certify the final capitation rates paid per rate cell under each contract and document the underlying data, assumptions, and methodologies.

(c) The commissioner may pay a managed care organization a capitation rate under a managed care contract that is different than the capitation rate paid to another managed care organization, if each capitation rate per rate cell that is paid is independently developed and set in accordance with Code of Federal Regulations, part 42, sections 438.4, 438.5, 438.6, and 438.8. The commissioner may increase or decrease the capitation rate per rate cell in accordance with Code of Federal Regulations, part 42, sections 438.4, paragraph (b), clause (4), and 438.7, paragraph (c), up to 1.5 percent without submitting a revised rate certification.

(d) If the commissioner determines that a retroactive adjustment to the capitation rate is necessary, the retroactive adjustment must be supported by a rationale for the adjustment and the data. Assumptions and methodologies used to develop the adjustment must be described with enough detail to allow the Centers for Medicare and Medicaid Services or an actuary to determine the reasonableness of the adjustment. Any retroactive adjustments must be certified by an actuary in a revised rate certification and submitted to the Centers for Medicare and Medicaid Services for approval as a contract amendment. All adjustments are subject to timely federal claim filing requirements.

(e) The commissioner shall, upon request from the Centers for Medicare and Medicaid Services, provide additional information if the Centers for Medicare and Medicaid Services determines the information is pertinent to certification approval. The commissioner shall identify whether the additional information shall be provided by the commissioner, the actuary, or another party.

Subd. 8. **Medical loss ratio.** (a) The commissioner shall require that each managed care organization calculate and submit to the commissioner a medical loss ratio report for each contract year. The calculation of the medical loss ratio in the medical loss ratio reporting year must be the ratio of the numerator to the denominator. The numerator must be the sum of the managed care organization's incurred claims, the managed care organization's expenditures for activities that improve health care quality, and fraud prevention activities. The denominator must be calculated as the managed care organization's adjusted premium revenue

minus the managed care organization's federal, state, and local taxes and licensing and regulatory fees identified in Code of Federal Regulations, part 42, section 438.8, paragraph (f), clause (3). The total amount of the denominator for a managed care organization that is assumed by another managed care organization must be reported by the assuming managed care organization for the entire medical loss ratio reporting year. The managed care organization must aggregate the data for all eligibility groups covered under the contract, unless the commissioner requires separate reporting and a separate medical loss ratio calculation for specific populations.

(b) Incurred claims must be identified by the expenditures, liabilities, reserves, deductions, and exclusions in accordance with Code of Federal Regulations, part 42, section 438.8, paragraph (e), clause (2).

(c) Activities that improve health care quality must be in one category in accordance with Code of Federal Regulations, part 42, section 438.8, paragraph (e), clause (3).

(d) Fraud prevention activities, including managed care organization expenditures on activities related to fraud prevention must be identified in accordance with Code of Federal Regulations, part 45, section 158.

(e) Premium revenue must include capitation payments; onetime payments for specific life events of enrollees; other payments to the managed care organization in accordance with Code of Federal Regulations, part 42, section 438.6, paragraph (b), clause (3); unpaid cost-sharing amounts; and changes to unearned premium reserves, net payments, and receipts related to risk-sharing mechanisms.

(f) When calculating the medical loss ratio, each expense must be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be prorated between types of expenses. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on a pro rata basis. Expenses must be allocated using the methods described in Code of Federal Regulations, part 42, section 438.8, paragraph (g), clause (2).

(g) The commissioner may require the managed care organization to provide a remittance if the medical loss ratio for the medical loss ratio reporting year does not meet the minimum medical loss ratio standard of 85 percent, or if applicable, a higher ratio mandated by the commissioner.

Subd. 9. **Reports.** (a) The commissioner shall require each managed care organization to submit a report to the commissioner for each medical loss ratio reporting year that includes the information identified in Code of Federal Regulations, part 42, section 438.8, paragraph (k). The report must be submitted within 12 months of the end of each medical loss ratio reporting year. The managed care organization must require any third-party vendor providing claims adjudication to provide all underlying data associated with medical loss ratio reporting to the managed care organization within 180 days of the end of the medical loss ratio reporting year or within 30 days of being requested by the managed care organization to calculate and validate the accuracy of medical loss ratio reporting. The managed care organization must include with the medical loss ratio report an attestation as to the accuracy of the calculation of the medical loss ratio.

(b) The commissioner shall annually submit to the Centers for Medicare and Medicaid Services a summary description of the reports received from the managed care organizations in accordance with Code of Federal Regulations, part 42, section 438.8, paragraph (k), along with the rate certification required under subdivision 7. At a minimum, the summary description must include for the medical loss ratio report reporting year, the amount of the numerator, the amount of the denominator, the medical loss ratio percentage achieved, the number of member months, and any remittances owed. If through the contract the commissioner requires the managed care organization to pay remittances for not meeting the minimum medical loss ratio, the commissioner must reimburse the Centers for Medicare and Medicaid Services the federal share that reflects

any differences in the federal matching rate. If a remittance is owed, the commissioner shall submit with the required report a separate report describing the methodology used to determine the state and federal shares of the remittance.

(c) If the commissioner makes a retroactive change to the capitation payments for a medical loss ratio reporting year for which the report was already submitted to the commissioner, the managed care organization shall recalculate the medical loss ratio for that year and submit a new report meeting the reporting requirements under paragraph (a).

(d) The commissioner may exempt a newly contracted managed care organization from calculating and reporting the medical loss ratio for the first year of the managed care organization's operation as required under this subdivision. If a managed care organization is excluded, the managed care organization must comply with the requirements of this section during the next medical loss ratio reporting year.

History: *1Sp2017 c 6 art 15 s 7; 2021 c 30 art 1 s 18*

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 must 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 of human services shall not approve or implement an initiative that consolidates funding appropriated for state-operated services with funding for managed care initiatives for persons with disabilities.

Subd. 2. MS 2022 [Repealed, 2024 c 79 art 10 s 5]

History: *1997 c 203 art 9 s 13; 2024 c 79 art 9 s 11*

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.695 COUNTY-ADMINISTERED RURAL MEDICAL ASSISTANCE PROGRAM.

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

(b) "CARMA" means the county-administered rural medical assistance program established under this section.

(c) "Commissioner" means the commissioner of human services.

(d) "Eligible individual" means an individual who is:

(1) residing in a county administering CARMA; and

(2) eligible for medical assistance, MinnesotaCare, Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+), or Special Needs Basic Care (SNBC).

(e) "Enrollee" means an individual enrolled in CARMA.

(f) "PMAP" means the prepaid medical assistance program under section 256B.69.

(g) "Rural county" has the meaning given to "rural area" in Code of Federal Regulations, title 42, section 438.52.

Subd. 2. **Program established.** CARMA is established to:

(1) provide a county-owned and county-administered alternative to PMAP;

(2) facilitate integration of health care, public health, and social services to address health-related social needs in rural communities;

(3) account for the fewer enrollees and local providers of health care and community services in rural communities; and

(4) promote accountability for health outcomes, health equity, customer service, community outreach, and cost of care.

Subd. 3. **County participation.** Each county or group of counties authorized under section 256B.692 may administer CARMA for any or all eligible individuals as an alternative to PMAP, MinnesotaCare, MSHO, MSC+, or SNBC programs. Counties choosing and authorized to administer CARMA are exempt from the procurement process as required under section 256B.69.

Subd. 4. **Oversight and regulation.** CARMA is governed by sections 256B.69 and 256B.692, unless otherwise provided for under this section. The commissioner must develop and implement a procurement process requiring applications from county-based purchasing plans interested in offering CARMA. The procurement process must require county-based purchasing plans to demonstrate compliance with federal and state regulatory requirements and the ability to meet the goals of the program set forth in subdivision 2. The commissioner must review and approve or disapprove applications.

Subd. 5. **CARMA enrollment.** (a) Subject to paragraph (d), eligible individuals must be automatically enrolled in CARMA, but may decline enrollment. Eligible individuals may enroll in fee-for-service medical assistance. Eligible individuals may change their CARMA elections on an annual basis.

(b) Eligible individuals must be able to enroll in CARMA through the selection process in accordance with the election period established in section 256B.69, subdivision 4, paragraph (e).

(c) Enrollees who were not previously enrolled in the medical assistance program or MinnesotaCare can change their selection once within the first year after enrollment in CARMA. Enrollees who were not previously enrolled in CARMA have 90 days to make a change and changes are allowed for additional special circumstances.

(d) The commissioner may not offer a second health plan to eligible individuals other than, or in addition to, CARMA except that the commissioner may offer a second health plan to eligible individuals enrolling in MinnesotaCare, if required by federal law or rule. Eligible individuals who do not select a health plan at the time of enrollment must automatically be enrolled in CARMA.

(e) The commissioner may offer a replacement plan to eligible individuals, as determined by the commissioner, when counties administering CARMA have their contract terminated for cause.

(f) The commissioner may, on a county-by-county basis, offer a health plan other than CARMA to individuals who are eligible for both Medicare and medical assistance due to age, income, or disability if there is not already a health plan available under CARMA.

(g) This subdivision supersedes section 256B.694.

[See Note.]

Subd. 6. **Benefits and services.** (a) Counties or groups of counties administering CARMA must cover all benefits and services required to be covered by medical assistance under section 256B.0625.

(b) Counties or groups of counties administering CARMA may reimburse enrollees directly for out-of-pocket costs incurred obtaining assessed HRSN services provided by nontraditional providers who are unable to accept payment via traditional health insurance methods. Enrollees must not be reimbursed for out-of-pocket costs paid to providers eligible to enroll.

Subd. 7. **Payment.** (a) The commissioner, in consultation with counties and groups of counties administering CARMA, must develop a mechanism for making payments to counties and groups of counties that administer CARMA. The payment mechanism must:

(1) be governed by contracts with terms, including but not limited to payment rates, amended on an as-needed basis;

(2) pay a full-risk monthly capitation payment for services included in CARMA, including the cost for administering CARMA benefits and services;

(3) include risk corridors based on minimum loss ratio, total cost of care, or other metrics;

(4) include a settle-up process tied to the risk corridor arrangement allowing a county or group of counties administering CARMA to retain savings for reinvestment in health care activities and operations to protect against significant losses that a county or group of counties administering CARMA or the state might realize, beginning no sooner than after a county's or group of counties' third year of CARMA operations;

(5) include a collaborative rate-setting process accounting for CARMA experience, regional experience, and the Department of Human Services fee-for-service experience; and

(6) be exempt from section 256B.69, subdivisions 5a, paragraphs (c) and (f), and 5d, and payment for Medicaid services provided under section 256B.69, subdivision 28, paragraph (b), no sooner than three years after CARMA implementation.

(b) Payments for benefits and services under subdivision 6, paragraph (a), must not exceed payments that otherwise would have been paid to health plans under medical assistance for that county or region.

Subd. 8. **Quality measures.** (a) The commissioner and counties and groups of counties administering CARMA must collaborate to establish quality measures for CARMA not to exceed the extent of quality measures required under sections 256B.69 and 256B.692. The measures must include:

(1) enrollee experience and outcomes;

(2) population health;

(3) health equity; and

(4) the value of health care spending.

(b) The commissioner and counties and groups of counties administering CARMA must collaborate to define a quality improvement model for CARMA. The model must include a focus on locally specified measures based on counties' unique needs. The locally specified measures for the county or group of counties administering CARMA must be determined before the commissioner enters into any contract with a county or group of counties.

Subd. 9. **Data and systems integration.** The commissioner and counties and groups of counties administering CARMA must collaborate to:

(1) identify and address barriers that prevent counties and groups of counties administering CARMA from reviewing individual enrollee eligibility information to identify eligibility and to help enrollees apply for other appropriate programs and resources;

(2) identify and address barriers preventing counties and groups of counties administering CARMA from more readily communicating with and educating potential and current enrollees regarding other program opportunities, including helping enrollees apply for those programs and navigate transitions between programs;

(3) develop and test, in counties participating in CARMA, a universal public assistance application form to reduce the administrative barriers associated with applying for and participating in various public programs;

(4) identify and address regulatory and system barriers that may prohibit counties and groups of counties administering CARMA, agencies, and other partners from working together to identify and address an individual's needs;

(5) facilitate greater interoperability between counties and groups of counties administering CARMA, agencies, and other partners to send and receive the data necessary to support CARMA, counties, and local health system efforts to improve the health and welfare of prospective and enrolled populations;

(6) support efforts of counties and groups of counties administering CARMA to incorporate the necessary automation and interoperability to eliminate manual processes when related to the data exchanged; and

(7) support the creation and maintenance by counties and groups of counties administering CARMA of an updated electronic inventory of community resources available to assist the enrollee in the enrollee's HRSN, including an electronic closed-loop referral system.

History: *1Sp2025 c 3 art 8 s 25; 2026 c 127 art 5 s 11*

NOTE: This section, as added by Laws 2025, First Special Session chapter 3, article 8, section 25, is effective January 1, 2028, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2025, First Special Session chapter 3, article 8, section 25, the effective date, as amended by Laws 2026, chapter 127, article 5, section 16.

NOTE: The amendment to subdivision 5 by Laws 2026, chapter 127, article 5, section 11, is effective January 1, 2028. Laws 2026, chapter 127, article 5, section 11, the effective date.

256B.696 PRESCRIPTION DRUGS; STATE PHARMACY BENEFIT MANAGER.

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

(b) "Managed care enrollees" means medical assistance and MinnesotaCare enrollees receiving coverage from managed care plans.

(c) "Managed care organizations" means health plan companies and county-based purchasing organizations providing coverage to medical assistance and MinnesotaCare enrollees under the managed care delivery system.

(d) "State pharmacy benefit manager" means the pharmacy benefit manager selected pursuant to the procurement process in subdivision 2.

[See Note.]

Subd. 2. **Procurement process.** (a) The commissioner must, through a competitive procurement process in compliance with paragraph (b), select a state pharmacy benefit manager to comply with the requirements set forth in subdivision 3. The state pharmacy benefit manager selected under this subdivision must be a prepaid ambulatory health plan, as defined in Code of Federal Regulations, title 42, section 438.2.

(b) When selecting the state pharmacy benefit manager, the commissioner must:

(1) accept applications for entities seeking to become the state pharmacy benefit manager;

(2) establish eligibility criteria an entity must meet in order to become the state pharmacy benefit manager; and

(3) enter into a master contract with a single pharmacy benefit manager.

(c) Applicants for the state pharmacy benefit manager must disclose to the commissioner the following during the procurement process:

(1) any activity, policy, practice, contract, or arrangement of the pharmacy benefit manager that may directly or indirectly present any conflict of interest with the pharmacy benefit manager's relationship with or obligation to the Department of Human Services or a managed care organization;

(2) all common ownership, members of a board of directors, managers, or other control of the pharmacy benefit manager or any of the pharmacy benefit manager's affiliated companies with:

(i) a managed care organization administering medical assistance or MinnesotaCare benefits in Minnesota or an affiliate of the managed care organization;

(ii) an entity that contracts on behalf of a pharmacy or any pharmacy services administration organization and its affiliates;

(iii) a drug wholesaler or distributor and its affiliates;

(iv) a third-party payer and its affiliates; or

(v) a pharmacy and its affiliates;

(3) any direct or indirect fees, charges, or any kind of assessments imposed by the pharmacy benefit manager on pharmacies licensed in the state with which the pharmacy benefit manager shares common

ownership, management, or control, or that are owned, managed, or controlled by any of the pharmacy benefit manager's affiliated companies;

(4) any direct or indirect fees, charges, or any kind of assessments imposed by the pharmacy benefit manager on pharmacies licensed in the state; and

(5) any financial terms and arrangements between the pharmacy benefit manager and a prescription drug manufacturer or labeler, including formulary management, drug substitution programs, educational support claims processing, or data sales fees.

[See Note.]

Subd. 3. **Contract requirements.** The master contract required under subdivision 2, paragraph (b), clause (3), must include provisions that prohibit the state pharmacy benefit manager from:

(1) requiring, enticing, or coercing an enrollee to obtain pharmacy services, including a prescription drug, from a pharmacy owned or otherwise affiliated with the state pharmacy benefit manager;

(2) communicating to an enrollee, in any manner, that the enrollee is required to obtain pharmacy services or have a prescription dispensed at, or pharmacy services provided by, a particular pharmacy owned or affiliated with the state pharmacy benefit manager if there are other nonaffiliated pharmacies that have the ability to dispense the medication or provide the services and are also in network;

(3) requiring an enrollee to obtain pharmacy services, including a prescription drug, exclusively through a mail order pharmacy;

(4) directly or indirectly retroactively denying or reducing a claim or aggregate of claims for pharmacy services, including prescription drugs, after adjudication of the claim or aggregation of claims; and

(5) paying a rate for pharmacy services, including the prescription drug, that is less than the sum of the following:

(i) the amount of the professional dispensing fee if it were determined pursuant to section 256B.0625, subdivision 13e; and

(ii) either:

(A) the lower of the national average drug acquisition cost or the Minnesota actual acquisition cost under section 256B.0625, subdivision 13e, paragraph (i);

(B) the maximum allowable cost, as described in section 62W.08, if the national average drug acquisition cost and the Minnesota actual acquisition cost are unreported; or

(C) the wholesale acquisition cost minus two percent at the time the drug is administered or dispensed if the costs of subitems (A) and (B) are unreported or unavailable.

[See Note.]

Subd. 4. **Prescription drug coverage requirements.** (a) The state pharmacy benefit manager is responsible for processing all point of sale outpatient pharmacy claims under the managed care delivery system. Managed care and county-based purchasing plans must use the state pharmacy benefit manager pursuant to the terms of the master contract required under subdivision 2, paragraph (b), clause (3). The state pharmacy benefit manager selected is the exclusive pharmacy benefit manager used by managed care and county-based purchasing plans when providing coverage to enrollees. The commissioner may require

the managed care and county-based purchasing plans and state pharmacy benefit manager to directly exchange data and files for members enrolled with the plans.

(b) The commissioner may require the state pharmacy benefit manager to modify utilization review limitations, requirements, and strategies imposed on prescription drug coverage.

(c) All payment arrangements between the Department of Human Services, managed care plans, county-based purchasing plans, and the state pharmacy benefit manager must comply with state and federal statutes, regulations adopted by the Centers for Medicare and Medicaid Services, and any other agreement between the department and the Centers for Medicare and Medicaid Services. The commissioner may change a payment arrangement to comply with this paragraph.

(d) The commissioner must administer and oversee this section to:

(1) ensure proper administration of prescription drug benefits for managed care enrollees; and

(2) increase the transparency of prescription drug prices and other information for the benefit of pharmacies.

[See Note.]

Subd. 5. **Reporting requirements.** (a) The state pharmacy benefit manager must, on request from the commissioner, disclose to the commissioner all sources of payment the state pharmacy benefit manager receives for prescribed drugs, including drug rebates, discounts, credits, clawbacks, fees, grants, chargebacks, reimbursements, or other financial benefits or payments related to services provided for a managed care or county-based purchasing plan.

(b) Each managed care and county-based purchasing plan must disclose to the commissioner, in the format specified by the commissioner, the entity's administrative costs associated with providing pharmacy services under the managed care delivery system.

(c) The state pharmacy benefit manager must provide a written quarterly report to the commissioner containing the following information from the immediately preceding quarter:

(1) the prices the state pharmacy benefit manager negotiated for prescribed drugs under the managed care delivery system. The prices must include any rebates the state pharmacy benefit manager received from drug manufacturers;

(2) unredacted copies of contracts between the state pharmacy benefit manager and enrolled pharmacies;

(3) any rebate amounts the state pharmacy benefit manager passed on to individual pharmacies;

(4) any changes to the information previously disclosed in accordance with subdivision 2, paragraph (c); and

(5) any other information required by the commissioner.

(d) Data submitted pursuant to paragraph (c), clause (3), are nonpublic data, as defined in section 13.02, subdivision 9.

(e) The commissioner may request and collect additional information and clinical data from the state pharmacy benefit manager.

(f) At the time of contract execution, renewal, or modification, the commissioner must modify the reporting requirements under its managed care contracts as necessary to meet the requirements of this subdivision.

[See Note.]

Subd. 6. **Commissioner's program authority.** (a) To accomplish the requirements of subdivision 4, paragraph (d), the commissioner, in consultation with the Formulary Committee established under section 256B.0625, subdivision 13c, has the authority to:

(1) adopt or develop a preferred drug list for managed care plans;

(2) at the commissioner's discretion, engage in price negotiations with prescription drug manufacturers, wholesalers, or group purchasing organizations in place of the state pharmacy benefit manager to obtain price discounts and rebates for prescription drugs for managed care enrollees; and

(3) develop and manage a drug formulary for managed care and county-based purchasing plans.

(b) The commissioner may contract with one or more entities to perform any of the functions described in paragraph (a).

[See Note.]

Subd. 7. **Contracts with pharmacies.** (a) The commissioner may review contracts between the state pharmacy benefit manager and pharmacies for compliance with this section and the master contract required under subdivision 2, paragraph (b), clause (3). The commissioner may amend any term or condition of a contract that does not comply with this section or the master contract.

(b) A master contract and a contract between a state pharmacy benefit manager and a pharmacy are nonpublic data, as defined in section 13.02, subdivision 9.

[See Note.]

Subd. 8. **Federal approval.** (a) The commissioner must seek any necessary federal approval to implement this section.

(b) The commissioner shall monitor the effect of state directed payments under this section on access to pharmaceutical services in rural and underserved areas of Minnesota. If, for any contract year, federal approval is not received for a state directed payment under this section, the commissioner must adjust payments made to the managed care entity for that contract year to reflect removal of the payment. Contracts between the state pharmacy benefit manager and providers to whom this section applies must allow recovery of payments from those providers if rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from state directed payments under this section. This paragraph expires if federal approval is not received for state directed payments under this section at any time.

History: *1Sp2025 c 3 art 4 s 9*

NOTE: Subdivisions 1 to 7, as added by Laws 2025, First Special Session chapter 3, article 4, section 9, are effective January 1, 2027, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2025, First Special Session chapter 3, article 4, section 9, the effective date.

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 substance use disorder 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; 2022 c 98 art 4 s 51*

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.

Subd. 4. **Payment for services.** Notwithstanding 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. MS 1990 [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; 2016 c 158 art 1 s 132*

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 or medical assistance; 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 to be maintained in good health, including emergency care; inpatient hospital and physician, advanced practice registered nurse, or physician assistant care; outpatient health services; and preventive health services.

(b) Services related to substance use disorder, 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 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. 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.

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. MS 1987 Supp [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; 2016 c 158 art 2 s 100,101; 2020 c 115 art 4 s 130; 2022 c 58 s 155; 2022 c 98 art 4 s 51*

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 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. MS 1998 [Repealed, 1999 c 245 art 4 s 120]

Subd. 3. MS 1998 [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. MS 1998 [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. MS 1991 Supp [Repealed, 1992 c 513 art 7 s 135]

Subd. 9. MS 1991 Supp [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 paid on a cost-based payment system that is based on the cost-finding methods and allowable costs of the Medicare program. Effective for services provided on or after July 1, 2015, rates established for critical access hospitals under this paragraph for the applicable payment year shall be the final payment and shall not be settled to actual costs. Effective for services delivered on or after the first day of the hospital's fiscal year ending in 2017, the rate for outpatient hospital services shall be computed using information from each hospital's Medicare cost report as filed with Medicare for the year that is two years before the year that the rate is being computed. Rates shall be computed using information from Worksheet C series until the department finalizes the medical assistance cost reporting process for critical access hospitals. After the cost reporting process is finalized, rates shall be computed using information from Title XIX Worksheet D series. The outpatient rate shall be equal to ancillary cost plus outpatient cost, excluding costs related to rural health clinics and federally qualified health clinics, divided by ancillary charges plus outpatient charges, excluding charges related to rural health clinics and federally qualified health clinics. Effective for services delivered on or after January 1, 2024, the rates paid to critical access hospitals under this section must be adjusted to include the amount of any distributions under section 62J.692, subdivision 4, paragraph (a), that were not included in the rate adjustment described under section 256.969, subdivision 2b, paragraph (k).

(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. When implementing prospective payment methodologies, the commissioner shall use general methods and rate calculation parameters similar to the applicable Medicare prospective payment systems for services delivered in outpatient hospital and ambulatory surgical center settings unless other payment methodologies for these services are specified in this chapter.

(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.

(g) Critical access hospitals that convert to rural emergency hospitals in accordance with section 1861(kkk) of the Social Security Act must be paid the rate described in paragraph (b). The rate must be classified as either an outpatient hospital rate or a clinic rate as determined upon federal approval.

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; 2015 c 71 art 11 s 38; 1Sp2017 c 6 art 4 s 49; 2020 c 115 art 3 s 32; 1Sp2021 c 7 art 1 s 21; 2023 c 70 art 5 s 14; 2026 c 127 art 5 s 12*

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. Never published [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*

256B.758 REIMBURSEMENT FOR DOULA SERVICES.

(a) Effective for services provided on or after July 1, 2019, through December 31, 2023, payments for doula services provided by a certified doula shall be $47 per prenatal or postpartum visit and $488 for attending and providing doula services at a birth.

(b) Effective for services provided on or after January 1, 2024, payments for doula services provided by a certified doula are $100 per prenatal or postpartum visit and $1,400 for attending and providing doula services at birth.

History: *1Sp2019 c 9 art 7 s 36; 2023 c 70 art 1 s 33*

256B.76 PHYSICIAN, PROFESSIONAL SERVICES, AND DENTAL REIMBURSEMENT.

Subdivision 1. **Physician and professional services reimbursement adjustments.** (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;

(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 registered 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 registered 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.

(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.

(g) Effective for services rendered on or after July 1, 2015, payment rates for physical therapy, occupational therapy, and speech pathology and related services provided by a hospital meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause (4), shall be increased by 90 percent from the rates in effect on June 30, 2015. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

(h) Any ratables effective before July 1, 2015, do not apply to early intensive developmental and behavioral intervention (EIDBI) benefits described in section 256B.0949.

(i) The commissioner may reimburse physicians and other licensed professionals for costs incurred to pay the fee for testing newborns who are medical assistance enrollees for heritable and congenital disorders under section 144.125, subdivision 1, paragraph (c), when the sample is collected outside of an inpatient hospital and the cost is not recognized by another payment source.

[See Note.]

Subd. 1a. **Certain long-term ambulatory electrocardiogram monitoring services.** (a) For the purpose of this subdivision, "long-term ambulatory electrocardiogram monitoring services" means the provision of external cardiac patch monitoring devices to patients to wear for 48 hours or greater and the interpretation of data gathered by such devices to detect heart arrhythmias that can lead to stroke, cardiac arrest, or other comorbidities or medical complications if not correctly diagnosed.

(b) Effective January 1, 2026, or upon federal approval, whichever is later, the commissioner must reimburse diagnostic testing facilities providing long-term ambulatory electrocardiogram monitoring services at 100 percent of the Medicare Physician Fee Schedule rate for such services or higher.

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) Effective for services rendered on or after January 1, 2014, through December 31, 2021, 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 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.

(i) Effective for services provided on or after January 1, 2017, through December 31, 2021, the commissioner shall increase payment rates by 9.65 percent for dental services provided outside of the seven-county metropolitan area. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, or Indian health services. Effective January 1, 2017, payments to managed care plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect the payment increase described in this paragraph.

(j) Effective for services provided on or after July 1, 2017, through December 31, 2021, the commissioner shall increase payment rates by 23.8 percent for dental services provided to enrollees under the age of 21. This rate increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, or Indian health centers. This rate increase does not apply to managed care plans and county-based purchasing plans.

(k) Effective for services provided on or after January 1, 2022, the commissioner shall exclude from medical assistance and MinnesotaCare payments for dental services to public health and community health clinics the 20 percent increase authorized under Laws 1989, chapter 327, section 5, subdivision 2, paragraph (b).

(l) Effective for services provided on or after January 1, 2022, the commissioner shall increase payment rates by 98 percent for all dental services. This rate increase does not apply to state-operated dental clinics, federally qualified health centers, rural health centers, or Indian health services.

(m) Managed care plans and county-based purchasing plans shall reimburse providers at a level that is at least equal to the rate paid under fee-for-service for dental services. If, for any coverage year, federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed an amount equal to any increase in rates that results from this provision. If, for any coverage year, federal approval is not received for this paragraph, the commissioner shall not implement this paragraph for subsequent coverage years.

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) 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, 2016, through December 31, 2021, the commissioner shall increase reimbursement by 37.5 percent above the reimbursement rate that would otherwise be paid to the critical access dental provider, except as specified under paragraph (b). 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) For dental services rendered on or after July 1, 2016, through December 31, 2021, by a dental clinic or dental group that meets the critical access dental provider designation under paragraph (f), clause (4), and is owned and operated by a health maintenance organization licensed under chapter 62D, the commissioner shall increase reimbursement by 35 percent above the reimbursement rate that would otherwise be paid to the critical access provider.

(c) The commissioner shall increase reimbursement to dentists and dental clinics deemed by the commissioner to be critical access dental providers. For dental services provided on or after January 1, 2022, by a dental provider deemed to be a critical access dental provider under paragraph (f), the commissioner shall increase reimbursement by 20 percent above the reimbursement rate that would otherwise be paid to

the critical access dental provider. This paragraph does not apply to federally qualified health centers, rural health centers, state-operated dental clinics, or Indian health centers.

(d) Managed care plans and county-based purchasing plans shall increase reimbursement to critical access dental providers by at least the amount specified in paragraph (c). If, for any coverage year, federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed an amount equal to any increase in rates that results from this provision. If, for any coverage year, federal approval is not received for this paragraph, the commissioner shall not implement this paragraph for subsequent coverage years.

(e) Critical access dental payments made under this subdivision for dental services provided by a critical access dental provider to an enrollee of a managed care plan or county-based purchasing plan must not reflect any capitated payments or cost-based payments from the managed care plan or county-based purchasing plan. The managed care plan or county-based purchasing plan must base the additional critical access dental payment on the amount that would have been paid for that service had the dental provider been paid according to the managed care plan or county-based purchasing plan's fee schedule that applies to dental providers that are not paid under a capitated payment or cost-based payment.

(f) 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;

(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) hospital-based dental clinics owned and operated by a city, county, or former state hospital as defined in section 62Q.19, subdivision 1, paragraph (a), clause (4);

(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 the seven-county metropolitan area and 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; or

(ii) the dentist's office is located outside the seven-county metropolitan area and more than 25 percent of the dentist's patient encounters per year are with patients who are uninsured or covered by medical assistance or MinnesotaCare.

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 9570.3400, 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.** (a) 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 (RVUs). This change shall be budget neutral and the cost of implementing RVUs will be incorporated in the established conversion factor.

(b) Notwithstanding any other provision in this chapter modifying rates for the mental health services reimbursed under this paragraph, effective for services rendered on or after January 1, 2026, or on or after the date of federal approval, whichever is later, rates for mental health services reimbursed under the resource-based relative value scale (RBRVS) must be equal to 100 percent of the Medicare Physician Fee Schedule.

(c) Effective for services rendered on or after January 1, 2025, the commissioner shall increase capitation payments made to managed care plans and county-based purchasing plans to reflect the rate increases provided under this subdivision. Managed care plans and county-based purchasing plans must use the capitation rate increase provided under this paragraph to increase payment rates to the providers corresponding to the rate increases. The commissioner must monitor the effect of this rate increase on enrollee access to services under this subdivision. If for any contract year federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this paragraph. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this paragraph.

[See Note.]

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; 2015 c 21 art 1 s 58; 2015 c 71 art 11 s 39-41; 2016 c 158 art 1 s 133; 2016 c 189 art 19 s 17,18; 2017 c 40 art 1 s 79; 1Sp2017 c 6 art 4 s 50,51; 2018 c 182 art 1 s 53; 1Sp2021 c 7 art 1 s 22,23; 1Sp2021 c 14 art 11 s 11; 2023 c 25 s 145; 2023 c 70 art 1 s 34; 2024 c 127 art 61 s 27; 1Sp2025 c 3 art 8 s 26-28*

NOTE: The amendment to subdivision 1 by Laws 2025, First Special Session chapter 3, article 8, section 26, is effective upon federal approval of the amendment to Minnesota Statutes, section 256B.0625, subdivision 54, by Laws 2025, First Special Session, chapter 3, article 8, section 16. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2025, First Special Session chapter 3, article 8, section 26, the effective date.

NOTE: The amendments to subdivision 6 by Laws 2024, chapter 127, article 61, section 27, are effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2024, chapter 127, article 61, section 27, the effective date.

NOTE: The amendment to subdivision 6 by Laws 2025, First Special Session chapter 3, article 8, section 28, is effective on the later of the following: (1) federal approval of the medical assistance program changes in the amendments to subdivision 6; or (2) federal approval of all necessary federal waivers to implement the managed care organization assessment in Minnesota Statutes, section 256B.1976. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2025, First Special Session chapter 3, article 8, section 28, the effective date.

256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.

Subdivision 1. **Rates effective 2026.** (a) Effective for services rendered on or after January 1, 2026, or on or after the date of federal approval, whichever is later, the commissioner must establish and pay market-based payment rates for the following services:

(1) children's therapeutic services and supports under section 256B.0943;

(2) child and family psychoeducation services under section 256B.0671, subdivision 5;

(3) clinical care consultation services under section 256B.0671, subdivision 7;

(4) mental health certified family peer specialist services under section 256B.0616;

(5) adult day treatment services under section 256B.0671, subdivision 3;

(6) adult rehabilitative mental health services under section 256B.0623;

(7) adult mental health peer support specialist services under section 256B.0615;

(8) dialectical behavioral therapy under section 256B.0671, subdivision 6;

(9) explanation of findings under section 256B.0671, subdivision 4;

(10) mental health crisis response services under section 256B.0624;

(11) mental health provider travel time under section 256B.0625, subdivision 43;

(12) neuropsychological testing under section 256B.0671, subdivision 9;

(13) partial hospitalization services under section 256B.0671, subdivision 12; and

(14) psychotherapy services under section 256B.0671, subdivision 11, incorporating biofeedback.

(b) Rates established under paragraph (a) must:

(1) be based on the costs of the following factors:

(i) direct staff worker wages and benefits;

(ii) direct staff worker productivity;

(iii) program-related expenses; and

(iv) administrative costs; and

(2) must not be lower than:

(i) the payment rates recommended in the rate analysis required by Laws 2021, First Special Session chapter 7, article 17, section 18, and published by the Department of Human Services on January 22, 2024; or

(ii) the payment rates in effect on December 31, 2025.

Subd. 2. **Capitation payments.** Managed care and county-based purchasing plans must reimburse providers at an amount that is at least equal to the fee-for-service rate for services under this section. The commissioner must monitor the effect of this rate adjustment on enrollee access to behavioral health services. If for any contract year federal approval is not received for this subdivision, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this subdivision. Contracts between managed care plans and county-based purchasing plans and providers to whom this subdivision applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this subdivision. Payment recoveries must not exceed the amount equal to any increase in rates that results from this subdivision.

Subd. 3. **Inflation adjustment.** The commissioner must adjust the reimbursement rate for services under this section annually according to the change from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined using the Centers for Medicare and Medicaid Services Medicare Economic Index as forecasted in the fourth quarter of the calendar year before the rate year.

Subd. 4. **Exceptions.** This section does not apply to federally qualified health centers, rural health centers, Indian health services, or certified community behavioral health clinics or to cost-based rates or rates that are negotiated with the county.

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; 1Sp2017 c 6 art 4 s 52; 2018 c 182 art 1 s 54; 2021 c 30 art 17 s 108; 2023 c 70 art 1 s 35; 2024 c 80 art 8 s 68; 2024 c 127 art 61 s 28; 1Sp2025 c 3 art 8 s 29; 1Sp2025 c 9 art 4 s 48; 2026 c 88 art 1 s 133*

NOTE: The amendment to this section by Laws 2023, chapter 70, article 1, section 35, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2023, chapter 70, article 1, section 35, the effective date.

NOTE: The amendment to this section by Laws 2024, chapter 127, article 61, section 28, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2024, chapter 127, article 61, section 28, the effective date.

NOTE: The amendment to this section by Laws 2025, First Special Session chapter 3, article 8, section 29, is effective on the later of the following: (1) federal approval of the medical assistance program changes in the amendments to this section; or (2) federal approval of all necessary federal waivers to implement the managed care organization assessment in Minnesota Statutes, section 256B.1976. The commissioner shall notify the revisor of statutes when federal approval is obtained. The amendment to this section by Laws 2025, First Special Session chapter 3, article 8, section 29, prevails over the amendment to this section in Laws 2025, First Special Session chapter 9, article 4, section 48. Laws 2025, First Special Session chapter 3, article 8, section 29, the effective date.

NOTE: This section was also amended by Laws 2025, First Special Session chapter 9, article 4, section 48, to read as follows:

"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 rehabilitation 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) 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 256K.10. 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.

(d) Any ratables effective before July 1, 2015, do not apply to early intensive developmental and behavioral intervention (EIDBI) benefits described in section 256B.0949.

(e) Effective for services rendered on or after January 1, 2024, payment rates for behavioral health services included in the rate analysis required by Laws 2021, First Special Session chapter 7, article 17, section 18, except for adult day treatment services under section 256B.0671, subdivision 3; early intensive developmental and behavioral intervention services under section 256B.0949; and substance use disorder services under chapter 254B, must be increased by three percent from the rates in effect on December 31,

2023. Effective for services rendered on or after January 1, 2025, payment rates for behavioral health services included in the rate analysis required by Laws 2021, First Special Session chapter 7, article 17, section 18, except early intensive developmental behavioral intervention services under section 256B.0949 and substance use disorder services under chapter 254B, must be annually adjusted according to the change from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined using the Centers for Medicare and Medicaid Services Medicare Economic Index as forecasted in the fourth quarter of the calendar year before the rate year. For payments made in accordance with this paragraph, if and to the extent that the commissioner identifies that the state has received federal financial participation for behavioral health services in excess of the amount allowed under United States Code, title 42, section 447.321, the state shall repay the excess amount to the Centers for Medicare and Medicaid Services with state money and maintain the full payment rate under this paragraph. This paragraph does not apply to federally qualified health centers, rural health centers, Indian health services, certified community behavioral health clinics, cost-based rates, and rates that are negotiated with the county. This paragraph expires upon legislative implementation of the new rate methodology resulting from the rate analysis required by Laws 2021, First Special Session chapter 7, article 17, section 18.

(f) Effective January 1, 2024, the commissioner shall increase capitation payments made to managed care plans and county-based purchasing plans to reflect the behavioral health service rate increase provided in paragraph (e). Managed care and county-based purchasing plans must use the capitation rate increase provided under this paragraph to increase payment rates to behavioral health services providers. The commissioner must monitor the effect of this rate increase on enrollee access to behavioral health services. If for any contract year federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this provision."

256B.762 REIMBURSEMENT FOR HEALTH CARE SERVICES.

(a) 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.

(b) Effective for services provided on or after July 1, 2015, payment rates for managed care and fee-for-service visits for the following services shall be increased by ten percent over the rates in effect on June 30, 2015, when these services are provided as home health services under section 256B.0625, subdivision 6a:

(1) physical therapy;

(2) occupational therapy; and

(3) speech therapy.

The commissioner shall adjust managed care and county-based purchasing plan capitation rates to reflect the payment rates under this paragraph.

History: *1Sp2005 c 4 art 7 s 47; 2015 c 71 art 11 s 42*

256B.763 MS 2024 [Repealed, 2023 c 70 art 1 s 43]

256B.7631 MS 2016 [Repealed, 1Sp2017 c 6 art 8 s 77]

256B.7635 REIMBURSEMENT FOR EVIDENCE-BASED PUBLIC HEALTH NURSE HOME VISITS.

Effective for services provided on or after January 1, 2018, prenatal and postpartum follow-up home visits provided by public health nurses or registered nurses supervised by a public health nurse using evidence-based models shall be paid $140 per visit. Evidence-based postpartum follow-up home visits must be administered by home visiting programs that meet the United States Department of Health and Human Services criteria for evidence-based models and are identified by the commissioner of health as eligible to be implemented under the Maternal, Infant, and Early Childhood Home Visiting program. Home visits must target mothers and their children beginning with prenatal visits through age three for the child.

History: *1Sp2017 c 6 art 4 s 53*

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.

(c) Effective for services provided on or after January 1, 2024, payment rates for family planning, when such services are provided by an eligible community clinic as defined in section 145.9268, subdivision 1, and abortion services shall be increased by 20 percent. This increase does not apply to federally qualified health centers, rural health centers, or Indian health services.

History: *2007 c 147 art 5 s 15; 2013 c 108 art 6 s 29; 2023 c 70 art 1 s 37; 2024 c 127 art 55 s 13*

256B.765 PROVIDER RATE INCREASES.

(a) Effective July 1, 2001, within the limits of appropriations specifically for this purpose, the commissioner shall provide an annual inflation adjustment for the providers listed in paragraph (c). The index for the inflation adjustment must be based on the change in the Employment Cost Index for Private Industry Workers - Total Compensation forecasted by Data Resources, Inc., as forecasted in the fourth quarter of the calendar year preceding the fiscal year. The commissioner shall increase reimbursement or allocation rates by the percentage of this adjustment, and county boards shall adjust provider contracts as needed.

(b) The commissioner of 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 chapter 256S; waivered services under community access for disability inclusion 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 section 256B.0625, subdivision 8; occupational therapy services under section 256B.0625, subdivision 8a; speech-language therapy services under Minnesota Rules, part 9505.0390; respiratory therapy services under Minnesota Rules, part 9505.0295; alternative care services under section 256B.0913; adult residential program grants under section 245.73; 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; 2015 c 78 art 6 s 31; 2016 c 158 art 1 s 134; art 2 s 102; 2019 c 54 art 2 s 39*

256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.

Subdivision 1. **Payment reductions for base care services effective July 1, 2009.** 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.

Subd. 2. **Classification of therapies as basic care services.** The commissioner shall classify physical therapy services, occupational therapy services, and speech-language pathology and related services as basic care services. The reduction in subdivision 1 shall apply to physical therapy services, occupational therapy services, and speech-language pathology and related services provided on or after July 1, 2010.

Subd. 3. **Payment reductions to managed care plans effective October 1, 2009.** 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 in subdivision 1 effective July 1, 2009, and payments made to the plans shall be reduced effective October 1, 2010, to reflect the reduction in subdivision 1 effective July 1, 2010.

Subd. 4. **Temporary payment reductions effective September 1, 2011.** (a) 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.

(b) 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.

Subd. 5. **Payment increases effective September 1, 2014.** (a) 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.

(b) Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this subdivision.

Subd. 6. **Temporary payment reductions effective July 1, 2014.** 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.

Subd. 7. **Payment increases effective July 1, 2015.** (a) 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 as determined under subdivisions 9 and 10.

(b) Effective for services provided on or after July 1, 2015, payments for outpatient hospital facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics, and orthotics to a hospital meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause (4), shall be increased by 90 percent from the rates in effect on June 30, 2015.

(c) Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under paragraph (b).

Subd. 8. **Exempt services.** 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.

Subd. 9. **Individually priced items.** (a) Effective for services provided on or after July 1, 2015, the following categories of medical supplies and durable medical equipment shall be individually priced items: customized and other specialized tracheostomy tubes and supplies, electric patient lifts, and durable medical equipment repair and service.

(b) This subdivision does not apply to medical supplies and durable medical equipment subject to a volume purchase contract, products subject to the preferred diabetic testing supply program, and items provided to dually eligible recipients when Medicare is the primary payer for the item.

(c) The commissioner shall not apply any medical assistance rate reductions to durable medical equipment as a result of Medicare competitive bidding.

Subd. 10. **Rate increases effective July 1, 2015.** (a) Effective for services provided on or after July 1, 2015, medical assistance payment rates for durable medical equipment, prosthetics, orthotics, or supplies shall be increased as follows:

(1) payment rates for durable medical equipment, prosthetics, orthotics, or supplies that were subject to the Medicare competitive bid that took effect in January of 2009 shall be increased by 9.5 percent; and

(2) payment rates for durable medical equipment, prosthetics, orthotics, or supplies on the medical assistance fee schedule, whether or not subject to the Medicare competitive bid that took effect in January of 2009, shall be increased by 2.94 percent, with this increase being applied after calculation of any increased payment rate under clause (1).

(b) Paragraph (a) does not apply to medical supplies and durable medical equipment subject to a volume purchase contract, products subject to the preferred diabetic testing supply program, items provided to dually eligible recipients when Medicare is the primary payer for the item, and individually priced items identified in subdivision 9.

(c) Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect the rate increases in this subdivision.

Subd. 11. **Rates for ventilators.** (a) Effective for nonpressure support ventilators provided on or after January 1, 2016, the rate shall be the lower of the submitted charge or the Medicare fee schedule rate.

(b) Effective for pressure support ventilators provided on or after January 1, 2016, the rate shall be the lower of the submitted charge or 47 percent above the Medicare fee schedule rate.

(c) For payments made in accordance with this subdivision, if, and to the extent that, the commissioner identifies that the state has received federal financial participation for ventilators in excess of the amount allowed effective January 1, 2018, under United States Code, title 42, section 1396b(i)(27), the state shall repay the excess amount to the Centers for Medicare and Medicaid Services with state funds and maintain the full payment rate under this subdivision.

Subd. 12. **Rates subject to the upper payment limit.** Payment rates for durable medical equipment, prosthetics, orthotics or supplies, that are subject to the upper payment limit in accordance with section 1903(i)(27) of the Social Security Act, shall be paid the Medicare rate. Rate increases provided in this chapter shall not be applied to the items listed in this subdivision.

Subd. 13. **Temporary rates for enteral nutrition and supplies.** (a) For dates of service on or after July 1, 2023, through June 30, 2027, enteral nutrition and supplies must be paid according to this subdivision. If sufficient data exists for a product or supply, payment must be based upon the 50th percentile of the usual and customary charges per product code submitted to the commissioner, using only charges submitted per unit. Increases in rates resulting from the 50th percentile payment method must not exceed 150 percent of the previous fiscal year's rate per code and product combination. Data are sufficient if: (1) the commissioner has at least 100 paid claim lines by at least ten different providers for a given product or supply; or (2) in the absence of the data in clause (1), the commissioner has at least 20 claim lines by at least five different providers for a product or supply that does not meet the requirements of clause (1). If sufficient data are not available to calculate the 50th percentile for enteral products or supplies, the payment rate must be the payment rate in effect on June 30, 2023.

(b) This subdivision expires June 30, 2027.

Subd. 14. **Rates for enteral nutrition and supplies.** For dates of service on or after July 1, 2027, enteral nutrition and supplies must be paid according to this subdivision and updated annually each January 1. If sufficient data exists for a product or supply, payment must be based upon the 50th percentile of the usual and customary charges per product code submitted to the commissioner for the previous calendar year, using only charges submitted per unit. Increases in rates resulting from the 50th percentile payment method must

not exceed 150 percent of the previous year's rate per code and product combination. Data are sufficient if: (1) the commissioner has at least 100 paid claim lines by at least ten different providers for a given product or supply; or (2) in the absence of the data in clause (1), the commissioner has at least 20 claim lines by at least five different providers for a product or supply that does not meet the requirements of clause (1). If sufficient data are not available to calculate the 50th percentile for enteral products or supplies, the payment must be the manufacturer's suggested retail price of that product or supply minus 20 percent. If the manufacturer's suggested retail price is not available, payment must be the actual acquisition cost of that product or supply plus 20 percent.

Subd. 15. **Rates for phototherapy services.** For dates of service on or after July 1, 2025, the payment rate for phototherapy services provided to newborns in the home setting must include a service fee in the amount of $520 per patient episode, in addition to the daily rental rate for the medical equipment in subdivision 12. The commissioner shall provide an annual inflation adjustment for the phototherapy service fee. The index for the inflation adjustment must be based on the Consumer Price Index for All Urban Consumers increase published by the Bureau of Labor Statistics.

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; 2015 c 71 art 11 s 43; 2016 c 163 art 3 s 9; 2016 c 189 art 19 s 19; 1Sp2017 c 6 art 4 s 54; 1Sp2019 c 9 art 7 s 37; 2023 c 61 art 3 s 14; 2024 c 125 art 1 s 25; 2024 c 127 art 46 s 25; 1Sp2025 c 3 art 8 s 30; 1Sp2025 c 9 art 3 s 2*

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 July 1, 2015, this section shall not apply to durable medical equipment, prosthetics, orthotics, or supplies.

(e) This section does not apply to physical therapy, occupational therapy, speech pathology and related services, and basic care services provided by a hospital meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause (4).

History: *1Sp2010 c 1 art 16 s 29; 2013 c 108 art 6 s 31; 2014 c 312 art 24 s 41; 2015 c 71 art 11 s 44*

256B.77 COORDINATED SERVICE DELIVERY SYSTEM FOR PERSONS WITH DISABILITIES.

Subdivision 1. **Demonstration project for persons 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 persons with a disability 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.

(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.

(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 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.

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.

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 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) serious mental illness as defined in section 245.4871, subdivision 6; or

(3) developmental disability, or being a person with a developmental disability as defined in section 252A.02, or a related condition as defined in section 256B.02, subdivision 11.

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 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 intergovernmental contract, unless otherwise agreed to by the enrollee and the enrollee's legal representative, if any. Until a personal support plan is developed and agreed to by the enrollee, enrollees must have access to the same amount, type, setting, duration, and frequency of covered services that they had at the time of enrollment unless other covered services are needed. For an enrollee who is not receiving covered services at the time of enrollment and for enrollees whose personal support plan is being revised, access to the medical assistance benefit set must be assured until a personal support plan is developed or revised. If an enrollee chooses not to develop a personal support plan, the enrollee will be subject to the network and prior authorization requirements of the county administrative entity or service delivery organization 60 days after enrollment. An enrollee can choose to have a personal support plan developed at any time. The personal support plan must be based on choices, preferences, and assessed needs and strengths of the enrollee. The service coordinator shall develop the personal support plan, in consultation with the enrollee or the enrollee's legal representative and other individuals requested by the enrollee. The personal support plan must be updated as needed or as requested by the enrollee. Enrollees may choose not to have a personal support plan.

(n) The county administrative entity shall ensure timely authorization, arrangement, and continuity of needed and covered supports and services.

(o) The county administrative entity shall offer service coordination that fulfills the responsibilities under subdivision 12 and is appropriate to the enrollee's needs, choices, and preferences, including a choice of service coordinator.

(p) The county administrative entity shall contract with schools and other agencies as appropriate to provide otherwise covered medically necessary medical assistance services as described in an enrollee's

individual family support plan, as described in sections 125A.26 to 125A.48, or 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.

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.

(b) The commissioner shall monitor and evaluate annually the effect of the discount on consumers, the county authority, and providers of disability services. Findings shall be reported and recommendations made, as appropriate, to ensure that the discount effect does not adversely affect the ability of the county administrative entity or providers of services to provide appropriate services to eligible individuals, and does not result in cost shifting of eligible individuals to the county authority.

(c) For risk-sharing to occur under this subdivision, the aggregate fee-for-service cost of covered services provided by the county administrative entity under this section must exceed the aggregate sum of capitation payments made to the county administrative entity under this section. The county authority is required to maintain its current level of nonmedical assistance spending on enrollees. If the county authority spends less in nonmedical assistance dollars on enrollees than it spent the year prior to the contract year, the amount of underspending shall be deducted from the aggregate fee-for-service cost of covered services. The commissioner shall then compare the fee-for-service costs and capitation payments related to the services provided for the term of this contract. The commissioner shall base its calculation of the fee-for-service costs on application of the medical assistance fee schedule to services identified on the county administrative entity's encounter claims submitted to the commissioner. The aggregate fee-for-service cost shall not include any third-party recoveries or cost-avoided amounts.

If the commissioner finds that the aggregate fee-for-service cost is greater than the sum of the capitation payments, the commissioner shall settle according to the following schedule:

(1) For the first contract year for each project, the commissioner shall pay the county administrative entity 50 percent of the difference between the sum of the capitation payments and 100 percent of projected fee-for-service costs. For aggregate fee-for-service costs in excess of 100 percent of projected fee-for-service costs, the commissioner shall pay 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 integration 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 housing support services under chapter 256I, 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;

(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.6903, 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 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; and 626.557; and chapter 260E 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 intergovernmental 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 of human services may adjust the aggregate capitation payments, as specified in the intergovernmental contract or service delivery contract.

Subd. 23. MS 2006 [Repealed, 2007 c 133 art 2 s 13]

Subd. 24. MS 2000 [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 substance use disorder 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 program. Enrollees may obtain covered mental health and substance use disorder 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 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 substance use disorder 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; 2016 c 158 art 1 s 135; art 2 s 103; 2017 c 40 art 1 s 121; 1Sp2017 c 6 art 2 s 39; 1Sp2020 c 2 art 8 s 98; 2022 c 98 art 2 s 13; art 4 s 51; 2024 c 79 art 9 s 12; 2024 c 125 art 1 s 26; 2024 c 127 art 46 s 26; 2025 c 38 art 8 s 69; 2026 c 88 art 1 s 134,135*

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

(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) To be eligible for the medical assistance demonstration project, 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.

History: *1Sp2001 c 9 art 2 s 55; 2002 c 379 art 1 s 113; 2017 c 40 art 1 s 80*

256B.79 INTEGRATED CARE FOR HIGH-RISK PREGNANT WOMEN.

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

(b) "Adverse outcomes" means maternal opiate addiction, other reportable prenatal substance abuse, low birth weight, or preterm birth.

(c) "Qualified integrated perinatal care collaborative" or "collaborative" means a combination of (1) members of community-based organizations that represent communities within the identified targeted populations, and (2) local or tribally based service entities, including health care, public health, social services, mental health, substance use disorder treatment, and community-based providers, determined by the commissioner to meet the criteria for the provision of integrated care and enhanced services for enrollees within targeted populations.

(d) "Targeted populations" means pregnant medical assistance enrollees residing in communities identified by the commissioner as being at above-average risk for adverse outcomes.

Subd. 2. **Grant program established.** The commissioner shall implement a grant program to improve birth outcomes and strengthen early parental resilience for pregnant women who are medical assistance enrollees, are at significantly elevated risk for adverse outcomes of pregnancy, and are in targeted populations. The program must promote the provision of integrated care and enhanced services to these pregnant women, including postpartum coordination to ensure ongoing continuity of care, by qualified integrated perinatal care collaboratives.

Subd. 3. **Grant awards.** The commissioner shall award grants to qualifying applicants to support interdisciplinary, integrated perinatal care. Grant funds must be distributed through a request for proposals process to a designated lead agency within an entity that has been determined to be a qualified integrated perinatal care collaborative or within an entity in the process of meeting the qualifications to become a qualified integrated perinatal care collaborative. Grant awards must be used to support interdisciplinary, team-based needs assessments, planning, and implementation of integrated care and enhanced services for targeted populations. In determining grant award amounts, the commissioner shall consider the identified health and social risks linked to adverse outcomes and attributed to enrollees within the identified targeted population.

Subd. 4. **Eligibility for grants.** To be eligible for a grant under this section, an entity must meet qualifications established by the commissioner to be a qualified integrated perinatal care collaborative. These qualifications must include evidence that the entity has policies, services, and partnerships to support interdisciplinary, integrated care. The policies, services, and partnerships must meet specific criteria and be

approved by the commissioner. The commissioner shall review the collaborative's capacity for interdisciplinary, integrated care, to be reviewed at the commissioner's discretion. In determining whether the entity meets the qualifications for a qualified integrated perinatal care collaborative, the commissioner shall verify and review whether the entity's policies, services, and partnerships:

(1) optimize early identification of substance use disorder and substance abuse during pregnancy, effectively coordinate referrals and follow-up of identified patients to evidence-based or evidence-informed treatment, and integrate perinatal care services with behavioral health and substance abuse services;

(2) enhance access to, and effective use of, needed health care or Tribal health care services, public health or Tribal public health services, social services, mental health services, substance use disorder services, or services provided by community-based providers by bridging cultural gaps within systems of care and by integrating community-based paraprofessionals such as doulas and community health workers as routinely available service components;

(3) encourage patient education about prenatal care, birthing, and postpartum care, and document how patient education is provided. Patient education may include information on nutrition, reproductive life planning, breastfeeding, and parenting;

(4) integrate child welfare case planning with substance abuse treatment planning and monitoring, as appropriate;

(5) effectively systematize screening, collaborative care planning, referrals, and follow up for behavioral and social risks known to be associated with adverse outcomes and known to be prevalent within the targeted populations;

(6) facilitate ongoing continuity of care to include postpartum coordination and referrals for interconception care, continued treatment for substance abuse, identification and referrals for maternal depression and other chronic mental health conditions, continued medication management for chronic diseases, and appropriate referrals to Tribal or county-based social services agencies and Tribal or county-based public health nursing services; and

(7) implement ongoing quality improvement activities as determined by the commissioner, including collection and use of data from qualified providers on metrics of quality such as health outcomes and processes of care, and the use of other data that has been collected by the commissioner.

Subd. 5. **Gaps in communication, support, and care.** A collaborative receiving a grant under this section must identify and report gaps in the collaborative's communication, administrative support, and direct care, if any, that must be remedied for the collaborative to continue to effectively provide integrated care and enhanced services to targeted populations.

Subd. 6. MS 2022 [Repealed, 2024 c 127 art 66 s 25]

Subd. 7. MS 2018 [Repealed, 1Sp2019 c 9 art 7 s 47]

History: *2015 c 71 art 11 s 45; 1Sp2019 c 9 art 7 s 38-42; 1Sp2021 c 7 art 1 s 24,25; 2022 c 98 art 4 s 51*

256B.795 MATERNAL AND INFANT HEALTH REPORT.

(a) The commissioner of human services, in consultation with the commissioner of health, shall submit a biennial report beginning April 15, 2022, to the chairs and ranking minority members of the legislative committees with jurisdiction over health policy and finance on the effectiveness of state maternal and infant

health policies and programs addressing health disparities in prenatal and postpartum health outcomes. For each reporting period, the commissioner shall determine the number of women enrolled in the medical assistance program who are pregnant or are in the 12-month postpartum period of eligibility and the percentage of women in that group who, during each reporting period:

(1) received prenatal services;

(2) received doula services;

(3) gave birth by primary cesarean section;

(4) gave birth to an infant who received care in the neonatal intensive care unit;

(5) gave birth to an infant who was premature or who had a low birth weight;

(6) experienced postpartum hemorrhage;

(7) received postpartum care within six weeks of giving birth; and

(8) received a prenatal and postpartum follow-up home visit from a public health nurse.

(b) These measurements must be determined through an analysis of the utilization data from claims submitted during each reporting period and by any other appropriate means. The measurements for each metric must be determined in the aggregate stratified by race and ethnicity.

(c) The commissioner shall establish a baseline for the metrics described in paragraph (a) using calendar year 2017. The initial report due April 15, 2022, must contain the baseline metrics and the metrics data for calendar years 2019 and 2020. The following reports due biennially thereafter must contain the metrics for the preceding two calendar years.

(d) This section expires December 31, 2034.

History: *1Sp2021 c 7 art 1 s 26; 2024 c 127 art 66 s 16*

256B.81 MENTAL HEALTH PROVIDER APPEAL PROCESS.

If a county contract or certification is required to enroll as an authorized provider of mental health services under medical assistance, and if a county refuses to grant the necessary contract or certification, the provider may appeal the county decision to the commissioner. A recipient may initiate an appeal on behalf of a provider who has been denied certification. The commissioner shall determine whether the provider meets applicable standards under state laws and rules based on an independent review of the facts, including comments from the county review. If the commissioner finds that the provider meets the applicable standards, the commissioner shall enroll the provider as an authorized provider. The commissioner shall develop procedures for providers and recipients to appeal a county decision to refuse to enroll a provider. After the commissioner makes a decision regarding an appeal, the county, provider, or recipient may request that the commissioner reconsider the commissioner's initial decision. The commissioner's reconsideration decision is final and not subject to further appeal.

History: *1Sp2001 c 9 art 9 s 44; 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.0632, 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; 2025 c 38 art 7 s 9*

256B.83 MS 2004 [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 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 people to assist with accomplishing 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; 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 the participant 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.

(e) For the purposes of this section, notwithstanding the provisions of section 144A.43, subdivision 3, supports purchased under CFSS are not considered home care services.

Subd. 2. **Definitions.** (a) [Repealed by amendment, 2026 c 121 art 9 s 61]

(b) [Renumbered 256B.8502, subd 2]

(c) [Renumbered 256B.8502, subd 4]

(d) [Renumbered 256B.8502, subd 5]

(e) [Renumbered 256B.8502, subd 6]

(f) [Renumbered 256B.8502, subd 10]

(g) [Renumbered 256B.8502, subd 8]

(h) [Renumbered 256B.8502, subd 9]

(i) [Renumbered 256B.8502, subd 12]

(j) [Renumbered 256B.8502, subd 13]

(k) [Renumbered 256B.8502, subd 14]

(l) [Renumbered 256B.8502, subd 15]

(m) [Renumbered 256B.8502, subd 16]

(n) [Renumbered 256B.8502, subd 17]

(o) [Renumbered 256B.8502, subd 19]

(p) [Renumbered 256B.8502, subd 20]

(q) [Renumbered 256B.8502, subd 21]

(r) [Renumbered 256B.8502, subd 22]

(s) [Renumbered 256B.8502, subd 23]

(t) [Renumbered 256B.8502, subd 24]

(u) [Renumbered 256B.8502, subd 25]

(v) [Renumbered 256B.8502, subd 27]

(w) [Renumbered 256B.8502, subd 28]

(x) [Renumbered 256B.8502, subd 29]

(y) [Renumbered 256B.8502, subd 30]

(z) [Renumbered 256B.8502, subd 31]

(aa) [Renumbered 256B.8502, subd 32]

(bb) [Renumbered 256B.8502, subd 33]

(cc) [Renumbered 256B.8502, subd 35]

Subd. 3. **Eligibility.** (a) CFSS is available to a person who:

(1) is determined eligible for medical assistance under this chapter, excluding those under section 256B.057, subdivisions 3, 3a, 3b, and 4;

(2) is a participant in the alternative care program under section 256B.0913;

(3) is a waiver participant as defined under chapter 256S or section 256B.092, 256B.093, or 256B.49; or

(4) has medical services identified in a person'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.

(c) A pregnant woman eligible for medical assistance under section 256B.055, subdivision 6, is eligible for CFSS without federal financial participation if the woman: (1) is eligible for CFSS under paragraphs (a) and (b); and (2) does not meet institutional level of care, as determined under section 256B.0911.

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 benefit or other services available through the alternative care program.

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, subdivisions 17 to 21, 23, 24, and 29 to 31;

(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 assessor as defined in section 256B.0911 to the participant or the participant's representative and chosen CFSS providers within ten business days and must include the participant's right to appeal the assessment under section 256.045, subdivision 3.

Subd. 5a. **Temporary authorization without assessment.** The lead agency assessor may authorize a temporary authorization for CFSS services to be provided under the agency-provider model. The lead agency assessor may authorize a temporary authorization for CFSS services to be provided under the agency-provider model without using the assessment process described in subdivision 5. 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 subdivision shall have no bearing on a future authorization. For CFSS services needed beyond the 45-day temporary authorization, the lead agency must conduct an assessment as described in subdivision 5 and participants must use consultation services to complete their orientation and selection of a service model.

Subd. 6. **Community first services and supports 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 support plan identified in sections 256B.092, subdivision 1b, and 256S.10. The CFSS service delivery plan must be reviewed by the participant, the consultation services provider, and the agency-provider or FMS provider 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 provider 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 methods and supports used to address the needs as identified through an assessment of functional needs;

(5) include the participant's 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;

(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 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 provided according to subdivision 18a 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 CFSS service delivery plan must describe the units or dollar amount available to the participant. 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 agreement. The

amount used each month may vary, but additional funds must not be provided above the annual service authorization amount, determined according to subdivision 8, unless a change in condition is assessed and authorized by the certified assessor and documented in the support plan and CFSS service delivery plan.

(e) In assisting with the development or modification of the CFSS service delivery plan during the authorization time period, the consultation services provider shall:

(1) consult with the FMS provider on the spending budget when applicable; and

(2) consult with the participant or participant's representative, agency-provider, and case manager or care coordinator.

(f) The CFSS service delivery plan must be approved by the lead agency for participants without a case manager or care coordinator who is responsible for authorizing services. A case manager or care coordinator must approve the plan for a waiver or alternative care program participant.

Subd. 6a. **Person-centered planning process.** 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 times and locations convenient to the participant;

(4) reflect cultural considerations of the participant;

(5) include within the process strategies for solving conflict or disagreement, including clear conflict-of-interest guidelines as identified in Code of Federal Regulations, title 42, section 441.540, for all planning;

(6) provide the participant choices of the services and supports the participant receives and the staff providing those services and supports;

(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.

Subd. 7. **Community first services and supports; covered services.** 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:

(i) relate to a need identified in a participant's CFSS service delivery plan; and

(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;

(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) swimming lessons for a participant younger than 12 years of age whose disability puts the participant at a higher risk of drowning according to the Centers for Disease Control Vital Statistics System;

(7) services described under subdivision 17 provided by a consultation services provider meeting the requirements of subdivision 17a;

(8) services provided by an FMS provider as defined under subdivision 13a that is an enrolled provider with the department;

(9) CFSS services provided by a support worker who is a parent, stepparent, or legal guardian of a participant under age 18, or who is the participant's spouse. Covered services under this clause are subject to the limitations described in subdivision 7b;

(10) shared services meeting the shared services requirements of this section; and

(11) worker training and development services as described in subdivision 18a.

Subd. 7a. **Enhanced rate.** (a) An enhanced rate of 107.5 percent of the rate paid for CFSS must be paid for services provided to persons who qualify for ten or more hours of CFSS per day when provided by a support worker who meets the requirements of subdivision 16, paragraph (e). This paragraph expires upon the effective date of paragraph (b).

(b) Effective January 1, 2026, or upon federal approval, whichever is later, an enhanced rate of 112.5 percent of the rate paid for CFSS must be paid for services provided to persons who qualify for ten or more hours of CFSS per day when provided by a support worker who meets the requirements of subdivision 16, paragraph (e).

(c) An agency provider must use all additional revenue attributable to the rate enhancements under this subdivision for the wages and wage-related costs of the support workers, including any corresponding increase in the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, and workers' compensation premiums. The agency provider must not use the additional revenue attributable to any enhanced rate under this subdivision to pay for mileage reimbursement, health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, contributions to employee retirement accounts, or any other employee benefits.

(d) Any change in the eligibility criteria for the enhanced rate for CFSS as described in this subdivision and referenced in subdivision 16, paragraph (e), does not constitute a change in a term or condition for individual providers as defined in section 256B.0711, and is not subject to the state's obligation to meet and negotiate under chapter 179A.

Subd. 7b. **Services provided by parents and spouses.** (a) This subdivision applies to services and supports described in subdivision 7, clause (9).

(b) If multiple parents are support workers providing CFSS services to their minor child or children, each parent may provide up to 40 hours of medical assistance home and community-based services in any seven-day period regardless of the number of children served. The total number of hours of medical assistance home and community-based services provided by all of the parents must not exceed 80 hours in a seven-day period regardless of the number of children served.

(c) If only one parent is a support worker providing CFSS services to the parent's minor child or children, the parent may provide up to 60 hours of medical assistance home and community-based services in a seven-day period regardless of the number of children served.

(d) If a participant's spouse is a support worker providing CFSS services, the spouse may provide up to 60 hours of medical assistance home and community-based services in a seven-day period.

(e) Paragraphs (b) to (d) must not be construed to permit an increase in either the total authorized service budget for an individual or the total number of authorized service units.

(f) A parent or participant's spouse must not receive a wage that exceeds the current rate for a CFSS support worker, including wages, benefits, and payroll taxes.

Subd. 7c. **Shared services under the agency-provider model.** (a) The commissioner shall authorize shared services arrangements if the commissioner determines that a shared services arrangement is appropriate to meet all the participants' needs and sufficient to maintain the participants' health and safety. The commissioner must include a decision regarding authorization of shared services during the process of authorizing CFSS under subdivision 8. The commissioner must not reduce the total number of authorized units for a participant who elects to receive shared services.

(b) An agency-provider must offer a participant or the participant's representative the option of shared services, one-on-one services, or a combination of both shared services and one-on-one services when shared services are authorized by the commissioner. The option of shared services may be elected at the sole discretion of either the participant or the participant's representative. The participant or the participant's representative may withdraw from participating in a shared services arrangement at any time.

Subd. 7d. **Shared services rates under the agency-provider model.** The commissioner shall provide a rate system for shared services. For two participants sharing services, the rate paid to an agency-provider for the shared services must not exceed one and one-half times the rate paid for serving a single participant. For three participants sharing services, the rate paid to an agency-provider for the shared services must not exceed twice the rate paid for serving a single participant. These rates apply only when all criteria for shared services are met.

Subd. 7e. **Pass-through for shared services under the agency-provider model.** (a) Of the additional revenue for shared services provided to two participants, the agency-provider must use 90 percent for the purposes specified in paragraph (b). Of the additional revenue for shared services provided to three participants, the agency-provider must use 90 percent for the purposes specified in paragraph (b).

(b) An agency-provider must use the percentages of additional revenue for shared services specified in paragraph (a) for the wages and wage-related costs of the support worker providing the shared services. The agency-provider must not use additional revenue for shared services to pay for mileage reimbursements, uniform allowances, health and dental insurance, life insurance, disability insurance, long-term care insurance, contributions to employee retirement accounts when the contribution is not a function of wages, or any other employee benefits.

Subd. 7f. **Shared services under the budget model.** (a) A participant who intends to elect shared services under the budget model, or the participant's representative, must include a statement of this intention in the CFSS service delivery plan, must develop a plan for shared services when developing or amending the CFSS service delivery plan, and must follow the CFSS process for approval of the plan as required under subdivision 6.

(b) The commissioner shall authorize shared services arrangements if the commissioner determines that a shared services arrangement is appropriate to meet all the participants' needs and sufficient to maintain the participants' health and safety. The commissioner must include a decision regarding authorization of shared services during the process of authorizing CFSS under subdivision 8. The commissioner must not reduce the total authorized dollar amount available to a participant who elects to receive shared services.

(c) The participants, or participants' representatives as needed, who elect to share services under the budget model must jointly develop a shared services agreement with the support of the participants' representatives as needed. Any participant or any participant's representative may at any time withdraw from participating in a shared services agreement.

(d) The commissioner must develop and publish recommendations for negotiating wages for support workers providing shared services under the budget model.

Subd. 7g. **Pass-through for shared services under the budget model.** For shared services provided under the budget model, participant employers must pay the individual provider support worker providing the shared services a percentage of the minimum wage specified in the agreement negotiated under chapter 179A, as made applicable to individual providers under section 179A.54, that is in effect at the time the services are provided. The required percentages are specified in clauses (1) and (2):

(1) for shared services provided by an individual provider support worker to two participant employers, the two participant employers must collectively pay the individual provider support worker at least 150 percent of the applicable minimum wage; and

(2) for shared services provided by an individual provider support worker to three participant employers, the three participant employers must collectively pay the individual support worker at least 200 percent of the applicable minimum wage.

Subd. 8. **Determination of CFSS service authorization amount.** (a) All community first services and supports must be authorized by the commissioner or the commissioner's designee before services begin. 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;

(2) the presence of complex health-related needs; and

(3) the presence of Level I behavior.

(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 the person for five service units;

(2) Q home care rating requires Level I behavior and one to three dependencies in ADLs and qualifies the person for six service units;

(3) R home care rating requires a complex health-related need and one to three dependencies in ADLs and qualifies the person for seven service units;

(4) S home care rating requires four to six dependencies in ADLs and qualifies the person for ten service units;

(5) T home care rating requires four to six dependencies in ADLs and Level I behavior and qualifies the person for 11 service units;

(6) U home care rating requires four to six dependencies in ADLs and a complex health-related need and qualifies the person for 14 service units;

(7) V home care rating requires seven to eight dependencies in ADLs and qualifies the person for 17 service units;

(8) W home care rating requires seven to eight dependencies in ADLs and Level I behavior and qualifies the person for 20 service units;

(9) Z home care rating requires seven to eight dependencies in ADLs and a complex health-related need and qualifies the person for 30 service units; and

(10) EN home care rating includes ventilator dependency as defined in section 256B.0651, subdivision 1, paragraph (g). A person who meets the definition of ventilator-dependent and the EN home care rating and utilize a combination of CFSS and home care nursing services is limited to a total of 96 service units per day for those services in combination. Additional units may be authorized when a person'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;

(2) 30 additional minutes per day for each complex health-related need; and

(3) 30 additional minutes per day for each behavior under this clause that requires assistance at least four times per week:

(i) level I behavior 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 the time needed to perform activities of daily living is increased.

(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. This paragraph expires upon the effective date of paragraph (h).

(h) Effective January 1, 2026, or upon federal approval, whichever is later, the service budget for budget model participants shall be based on:

(1) assessed units as determined by the home care rating and the payment methodologies under section 256B.851; and

(2) an adjustment needed for administrative expenses.

Subd. 8a. **Authorization; exceptions.** All CFSS services must be authorized by the commissioner or the commissioner's designee as described in subdivision 8 except when:

(1) the lead agency temporarily authorizes services in the agency-provider model as described in subdivision 5a;

(2) CFSS services in the agency-provider model were required to treat an emergency medical condition that if not immediately treated could cause a participant serious physical or mental disability, continuation of severe pain, or death. The CFSS agency provider must request retroactive authorization from the lead agency no later than five working days after providing the initial emergency service. The CFSS agency provider must be able to substantiate the emergency through documentation such as reports, notes, and admission or discharge histories. A lead agency must follow the authorization process in subdivision 5 after the lead agency receives the request for authorization from the agency provider;

(3) the lead agency authorizes a temporary increase to the amount of services authorized in the agency or budget model to accommodate the participant's temporary higher need for services. Authorization for a temporary level of CFSS services is limited to the time specified by the commissioner, but shall not exceed 45 days. The level of services authorized under this clause shall have no bearing on a future authorization;

(4) a participant's medical assistance eligibility has lapsed, is then retroactively reinstated, and an authorization for CFSS services is completed based on the date of a current assessment, eligibility, and request for authorization;

(5) a third-party payer for CFSS 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;

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

(7) a participant enrolled in managed care experiences a temporary disenrollment from a health plan, in which case the commissioner shall accept the current health plan authorization for CFSS 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.

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 CFSS service delivery plan;

(2) are provided prior to the authorization of services and the approval of the CFSS service delivery plan;

(3) are duplicative of other paid services in the CFSS service delivery plan;

(4) supplant natural unpaid supports that appropriately meet a need in the CFSS service delivery 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;

(12) any service or good covered by other 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 adult participant's health condition. The condition must be identified in the participant's CFSS service delivery plan and monitored by a Minnesota health care program enrolled physician, advanced practice registered nurse, or physician's assistant;

(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;

(31) services provided by a foster care license holder except when the home of the person receiving services is the licensed foster care provider's primary residence;

(32) services that are the responsibility of the foster care provider under the terms of the foster care placement agreement, assessment under sections 142A.607 and 260C.4411, and administrative rules under sections 142A.607 and 260C.4411;

(33) services in a setting that has a licensed capacity greater than six, unless all conditions for a variance under section 142B.10, subdivision 17, are satisfied for a sibling, as defined in section 260C.007, subdivision 32;

(34) services from a provider who owns or otherwise controls the living arrangement, except when the provider of services is related by blood, marriage, or adoption or when the provider is a licensed foster care provider who is not prohibited from providing services under clauses (31) to (33);

(35) instrumental activities of daily living for children younger than 18 years of age, except when immediate attention is needed for health or hygiene reasons integral to an assessed need for assistance with activities of daily living, health-related procedures, and tasks or behaviors; or

(36) services provided to a resident of a nursing facility, hospital, intermediate care facility, or health care facility licensed by the commissioner of health.

Subd. 10. **Agency-provider and FMS provider qualifications and duties.** (a) Agency-providers identified in subdivision 11 and FMS providers identified in subdivision 13a shall:

(1) enroll as a medical assistance Minnesota health care programs provider and meet all applicable provider standards and requirements including completion of required provider training as determined by the commissioner;

(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; and

(9) have an office located in Minnesota.

(b) In conducting general duties, agency-providers and FMS providers 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 and that meets the requirements of subdivisions 20a, 20b, and 20c for agency-providers;

(6) report maltreatment as required under section 626.557 and chapter 260E;

(7) comply with the labor market reporting requirements described in section 256B.4912, subdivision 1a;

(8) comply with any data requests from the department consistent with the Minnesota Government Data Practices Act under chapter 13;

(9) maintain documentation for the requirements under subdivision 16, paragraph (e), clause (2), to qualify for an enhanced rate under this section; and

(10) request reassessments 60 days before the end of the current authorization for CFSS on forms provided by the commissioner.

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 agency-provider that meets the 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 CFSS service delivery plan. The agency must make a reasonable effort to fulfill the participant's request for the participant's preferred support worker.

(c) A participant may use authorized units of CFSS services as needed within a service agreement 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 CFSS 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, except all of the revenue generated by a medical assistance rate increase due to a collective bargaining agreement under section 179A.54 must be used 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 participants who are restricted by the Minnesota restricted recipient program under Minnesota Rules, parts 9505.2160 to 9505.2245.

(g) Participants purchasing goods under the agency-provider model, along with support worker services, must:

(1) specify the goods in the CFSS service delivery plan and detailed budget for expenditures that must be approved by the lead agency, case manager, or care coordinator; and

(2) use the FMS provider for the billing and payment of such goods.

(h) The agency provider is responsible for ensuring that any worker driving a participant under section 256B.8502, subdivision 19, has a valid driver's license and the vehicle used is registered and insured according to Minnesota law.

Subd. 11a. **Agency-provider model; evaluation of CFSS services.** (a) The agency-provider is responsible to work with the participant and the participant's representative, if any, in the evaluation of the CFSS goals and CFSS service delivery plan. The agency-provider must complete an evaluation of CFSS services within 90 days of service initiation and at least quarterly thereafter. Quarterly evaluations during the first year must be completed in person. Following the first year of service, at least one quarterly evaluation each year must be completed in person. An in-person evaluation must also be completed within 30 calendar days of the discovery or receipt of information of any changes in the participant's condition for which CFSS is provided.

(b) Each CFSS evaluation required in paragraph (a) must evaluate and document the required elements in clauses (1) to (5):

(1) whether the CFSS service delivery plan accurately identifies the participant's current service needs;

(2) whether services are supporting accomplishment of the goals identified in the CFSS service delivery plan;

(3) whether workers are competent in providing services identified in the CFSS service delivery plan;

(4) whether the agency-provider, the participant, or the participant's representative, if any, has any additional concerns with the CFSS service delivery plan, goals, service delivery, or worker competency not identified in clauses (1) to (3); and

(5) based on the evaluation required in clauses (1) to (4), whether revisions are needed to the CFSS service delivery plan or goals or how CFSS is used or delivered, whether there is a need for additional worker training, or whether any other actions are needed to support the participant's use of CFSS and who will take the action.

If changes are needed based on the results of the evaluation, a revised CFSS service delivery plan must be completed and provided to the participant or participant's representative, if any, within 30 calendar days of the evaluation.

Subd. 11b. **Agency-provider model; support worker competency.** (a) The agency-provider must ensure that support workers are competent to meet the participant's assessed needs, goals, and additional requirements as written in the CFSS service delivery plan. The agency-provider must evaluate the competency of the support worker through direct observation of the support worker's performance of the job functions in a setting where the participant is using CFSS within 30 days of:

(1) any support worker beginning to provide services for a participant; or

(2) any support worker beginning to provide shared services.

(b) The agency-provider must verify and maintain evidence of support worker competency, including documentation of the support worker's:

(1) education and experience relevant to the job responsibilities assigned to the support worker and the needs of the participant;

(2) relevant training received from sources other than the agency-provider;

(3) orientation and instruction to implement services and supports to participant needs and preferences as identified in the CFSS service delivery plan;

(4) orientation and instruction delivered by an individual competent to perform, teach, or assign the health-related tasks for tracheostomy suctioning and services to participants on ventilator support, including equipment operation and maintenance; and

(5) periodic performance reviews completed by the agency-provider at least annually, including any evaluations required under subdivision 11a, paragraph (a). If a support worker is a minor, all evaluations of worker competency must be completed in person and in a setting where the participant is using CFSS.

(c) The agency-provider must develop a worker training and development plan with the participant to ensure support worker competency. The worker training and development plan must be updated when:

(1) the support worker begins providing services;

(2) the support worker begins providing shared services;

(3) there is any change in condition or a modification to the CFSS service delivery plan; or

(4) a performance review indicates that additional training is needed.

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 email 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 purchased new annually, and must allow for recovery of costs and fees in pursuing a claim on the bond. Any action to obtain monetary recovery or sanctions from a surety bond must occur within six years from the date the debt is affirmed by a final agency decision. An agency decision is final when the right to appeal the debt has been exhausted or the time to appeal has expired under section 256B.064;

(3) proof of fidelity bond coverage in the amount of $20,000 per provider location;

(4) proof of workers' compensation insurance coverage;

(5) proof of liability insurance;

(6) a copy of the CFSS agency-provider's organizational chart identifying the names and roles of all owners, managing employees, staff, board of directors, and additional documentation reporting any affiliations of the directors and owners to other service providers;

(7) proof that the CFSS agency-provider has written policies and procedures including: hiring of employees; training requirements; service delivery; and employee and consumer safety, including the process for notification and resolution of participant grievances, incident response, identification and prevention of communicable diseases, and employee misconduct;

(8) proof that the CFSS agency-provider has all of the following forms and documents:

(i) a copy of the CFSS agency-provider's 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, except 100 percent of the revenue generated by a medical assistance rate increase due to a collective bargaining agreement under section 179A.54 must be used for support worker wages and benefits. 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 and 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.

(d) Agency-providers shall submit all required documentation in this section within 30 days of notification from the commissioner. If an agency-provider fails to submit all the required documentation, the commissioner may take action under subdivision 23a.

Subd. 12a. **CFSS agency-provider requirements; policies for complaint process and incident response.** (a) The CFSS agency-provider must establish policies and procedures that promote service recipient rights by providing a simple complaint process for participants served by the program and their authorized representatives to bring a grievance. The complaint process must:

(1) provide staff assistance with the complaint process when requested;

(2) allow the participant to bring the complaint to the highest level of authority in the program if the grievance cannot be resolved by other staff members, and provide the name, address, and telephone number of that person;

(3) provide the addresses and telephone numbers of outside agencies to assist the participant;

(4) require a prompt response to all complaints affecting a participant's health and safety and a timely response to all other complaints;

(5) require an evaluation of whether:

(i) related policies and procedures were followed and adequate;

(ii) there is a need for additional staff training;

(iii) the complaint is similar to past complaints with the persons, staff, or services involved; and

(iv) there is a need for corrective action by the agency-provider to protect the health and safety of participants receiving services;

(6) provide a written summary of the complaint and a notice of the complaint resolution to the participant and, if applicable, case manager or care coordinator; and

(7) require that the complaint summary and resolution notice be maintained in the participant's service record.

(b) The CFSS agency-provider must establish policies and procedures for responding to incidents that occur while services are being provided. When a participant has a legal representative or a participant's representative, incidents must be reported to these representatives. For the purposes of this paragraph, "incident" means an occurrence that involves a participant and requires a response that is not a part of the ordinary provision of the services to that participant, and includes:

(1) serious injury of a participant as determined by section 245.91, subdivision 6;

(2) a participant's death;

(3) any medical emergency, unexpected serious illness, or significant unexpected change in a participant's illness or medical condition that requires a call to 911, physician treatment, or hospitalization;

(4) any mental health crisis that requires a call to 911 or a mental health crisis intervention team;

(5) an act or situation involving a participant that requires a call to 911, law enforcement, or the fire department;

(6) a participant's unexplained absence;

(7) behavior that creates an imminent risk of harm to the participant or another; and

(8) a report of alleged or suspected child or vulnerable adult maltreatment under section 626.557 or chapter 260E.

Subd. 12b. **CFSS agency-provider requirements; notice regarding termination of services.** (a) An agency-provider must provide written notice when it intends to terminate services with a participant at least 30 calendar days before the proposed service termination is to become effective, except in cases where:

(1) the participant engages in conduct that significantly alters the terms of the CFSS service delivery plan with the agency-provider;

(2) the participant or other persons at the setting where services are being provided engage in conduct that creates an imminent risk of harm to the support worker or other agency-provider staff; or

(3) an emergency or a significant change in the participant's condition occurs within a 24-hour period that results in the participant's service needs exceeding the participant's identified needs in the current CFSS service delivery plan so that the agency-provider cannot safely meet the participant's needs.

(b) When a participant initiates a request to terminate CFSS services with the agency-provider, the agency-provider must give the participant a written acknowledgment of the participant's service termination request that includes the date the request was received by the agency-provider and the requested date of termination.

(c) The agency-provider must participate in a coordinated transfer of the participant to a new agency-provider to ensure continuity of care.

Subd. 12c. **Community first services and supports agency provider requirements; documentation of travel time.** A community first services and supports agency provider must ensure that travel and driving, as described in section 256B.8502, subdivision 19, is documented. The documentation must include:

(1) start and stop times with a.m. and p.m. designation;

(2) the origination site; and

(3) the destination site.

Subd. 13. **Budget model.** (a) Under the budget model participants exercise responsibility and control over the services and supports described and budgeted within the CFSS service delivery plan. Participants must use consultation services specified in subdivision 17 and services specified in subdivision 13a provided by an FMS provider. 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, family and medical benefit insurance, 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) If two or more participants using the budget model live in the same household and have the same support worker, the participants must use the same FMS provider.

(d) If the FMS provider advises that there is a joint employer in the budget model, all participants associated with that joint employer must use the same FMS provider.

(e) 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 is unable to fulfill the responsibilities under the budget model, as specified in subdivision 14.

(f) A participant may appeal in writing to the department under section 256.045, subdivision 3, to contest the department's decision under paragraph (e), clause (3), to disenroll or exclude the participant from the budget model.

Subd. 13a. **Financial management services.** (a) Services provided by an FMS provider include but are not limited to: filing and payment of federal and state payroll taxes and premiums on behalf of the participant; initiating and complying with background study requirements under chapter 245C and maintaining documentation of background study requests and results; 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, family and medical benefit insurance, 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.

(b) Agency-provider services shall not be provided by the FMS provider.

(c) The FMS provider 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 CFSS service delivery plan as requested by the consultation services provider or participant;

(2) data recording and reporting of participant spending;

(3) other duties established by the department, including with respect to providing assistance to the participant, participant's representative, or legal representative in performing employer responsibilities regarding support workers. The support worker shall not be considered the employee of the FMS provider; and

(4) billing, payment, and accounting of approved expenditures for goods.

(d) The FMS provider shall obtain an assurance statement from the participant employer agreeing to follow state and federal regulations and CFSS policies regarding employment of support workers.

(e) The FMS provider 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 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 chapter 268B and 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 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;

(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 provider 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; and

(7) provide written notice to the participant or the participant's representative at least 30 calendar days before a proposed service termination becomes effective, except in cases where:

(i) the participant engages in conduct that significantly alters the terms of the CFSS service delivery plan with the FMS;

(ii) the participant or other persons at the setting where services are being provided engage in conduct that creates an imminent risk of harm to the support worker or other staff; or

(iii) an emergency or a significant change in the participant's condition occurs within a 24-hour period that results in the participant's service needs exceeding the participant's identified needs in the current CFSS service delivery plan so that the plan cannot safely meet the participant's needs.

(f) The commissioner shall:

(1) establish rates and payment methodology for the FMS provider;

(2) identify a process to ensure quality and performance standards for the FMS provider and ensure statewide access to FMS providers; and

(3) establish a uniform protocol for delivering and administering CFSS services to be used by eligible FMS providers.

Subd. 14. **Participant's responsibilities.** (a) The participant or participant's representative is responsible for:

(1) orienting support workers to individual needs and preferences and providing direction during the delivery of services;

(2) tracking the services provided and all expenditures for goods or other supports;

(3) preparing, verifying, and submitting time sheets according to the requirements in subdivision 15;

(4) reporting any problems resulting from the failure of the CFSS service delivery plan to be implemented or the quality of services rendered by the support worker to the agency-provider, consultation services provider, FMS provider, and case manager or care coordinator if applicable;

(5) notifying the agency-provider or the FMS provider within ten days of any changes in circumstances affecting the CFSS service delivery plan, including but not limited to changes in the participant's place of residence or hospitalization; and

(6) under the agency-provider model, participating in the evaluation of CFSS services and support workers according to subdivision 11a.

(b) For a participant using the budget model, the participant or participant's representative is responsible for:

(1) using an FMS provider that is enrolled with the department. Upon a determination of eligibility and completion of the assessment and support plan, the participant shall choose an FMS provider from a list of eligible providers maintained by the department;

(2) complying with policies and procedures of the FMS provider as required to meet state and federal regulations for CFSS and the employment of support workers;

(3) 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;

(4) notifying the FMS provider of any changes in the employment status of each support worker;

(5) ensuring that support workers are competent to meet the participant's assessed needs and additional requirements as written in the CFSS service delivery plan;

(6) determining the competency of the support worker through evaluation within 30 days of any support worker beginning to provide services and with any change in the participant's condition or modification to the CFSS service delivery plan;

(7) verifying and maintaining evidence of support worker competency, including documentation of the support worker's:

(i) education and experience relevant to the job responsibilities assigned to the support worker and the needs of the participant;

(ii) training received from sources other than the participant;

(iii) orientation and instruction to implement defined services and supports to meet participant needs and preferences as detailed in the CFSS service delivery plan; and

(iv) periodic written performance reviews completed by the participant at least annually based on the direct observation of the support worker's ability to perform the job functions;

(8) developing and communicating to each support worker a worker training and development plan to ensure the support worker is competent when:

(i) the support worker begins providing services;

(ii) there is any change in the participant's condition or modification to the CFSS service delivery plan; or

(iii) a performance review indicates that additional training is needed;

(9) participating in the evaluation of CFSS services; and

(10) ensuring that a worker driving the participant under section 256B.8502, subdivision 19, has a valid driver's license and the vehicle used is registered and insured according to Minnesota law.

Subd. 14a. **Participant's representative responsibilities.** (a) If a participant is unable to direct the participant's own care, the participant must use a participant's representative to receive CFSS services. A participant's representative is required if:

(1) the person is under 18 years of age;

(2) the person has a court-appointed guardian; or

(3) an assessment according to section 256B.0659, subdivision 3a, determines that the participant is in need of a participant's representative.

(b) A participant's representative must:

(1) be at least 18 years of age;

(2) actively participate in planning and directing CFSS services;

(3) have sufficient knowledge of the participant's circumstances to use CFSS services consistent with the participant's health and safety needs identified in the participant's service delivery plan;

(4) not have a financial interest in the provision of any services included in the participant's CFSS service delivery plan; and

(5) be capable of providing the support necessary to assist the participant in the use of CFSS services.

(c) A participant's representative must not be the:

(1) support worker;

(2) worker training and development service provider;

(3) agency-provider staff, unless related to the participant by blood, marriage, or adoption;

(4) consultation service provider, unless related to the participant by blood, marriage, or adoption;

(5) FMS staff, unless related to the participant by blood, marriage, or adoption;

(6) FMS owner or manager; or

(7) lead agency staff acting as part of employment.

(d) A licensed family foster parent who lives with the participant may be the participant's representative if the family foster parent meets the other participant's representative requirements.

(e) There may be two persons designated as the participant's representative, including instances of divided households and court-ordered custodies. Each person named as the participant's representative must meet the program criteria and responsibilities.

(f) The participant or the participant's legal representative shall appoint a participant's representative. The participant's representative must be identified at the time of assessment and listed on the participant's service agreement and CFSS service delivery plan.

(g) A participant's representative must enter into a written agreement with an agency-provider or FMS on a form determined by the commissioner and maintained in the participant's file, to:

(1) be available while care is provided using a method agreed upon by the participant or the participant's legal representative and documented in the participant's service delivery plan;

(2) monitor CFSS services to ensure the participant's service delivery plan is followed;

(3) review and sign support worker time sheets after services are provided to verify the provision of services;

(4) review and sign vendor paperwork to verify receipt of goods; and

(5) in the budget model, review and sign documentation to verify worker training and development expenditures.

(h) A participant's representative may delegate responsibility to another adult who is not the support worker during a temporary absence of at least 24 hours but not more than six months. To delegate responsibility, the participant's representative must:

(1) ensure that the delegate serving as the participant's representative satisfies the requirements of the participant's representative;

(2) ensure that the delegate performs the functions of the participant's representative;

(3) communicate to the CFSS agency-provider or FMS provider about the need for a delegate by updating the written agreement to include the name of the delegate and the delegate's contact information; and

(4) ensure that the delegate protects the participant's privacy according to federal and state data privacy laws.

(i) The designation of a participant's representative remains in place until:

(1) the participant revokes the designation;

(2) the participant's representative withdraws the designation or becomes unable to fulfill the duties;

(3) the legal authority to act as a participant's representative changes; or

(4) the participant's representative is disqualified.

(j) A lead agency may disqualify a participant's representative who engages in conduct that creates an imminent risk of harm to the participant, the support workers, or other staff. A participant's representative who fails to provide support required by the participant must be referred to the common entry point.

Subd. 15. **Documentation of support services provided; time sheets.** (a) CFSS services provided to a participant by a support worker employed by either an agency-provider or the participant employer must be documented daily by each support worker, on a time sheet. Time sheets may be created, submitted, and maintained electronically. Time sheets must be submitted by the support worker at least once per month to the:

(1) agency-provider when the participant is using the agency-provider model. The agency-provider must maintain a record of the time sheet and provide a copy of the time sheet to the participant; or

(2) participant and the participant's FMS provider when the participant is using the budget model. The participant and the FMS provider must maintain a record of the time sheet.

(b) The documentation on the time sheet must correspond to the participant's assessed needs within the scope of CFSS covered services. The accuracy of the time sheets must be verified by the:

(1) agency-provider when the participant is using the agency-provider model; or

(2) participant employer and the participant's FMS provider when the participant is using the budget model.

(c) The time sheet must document the time the support worker provides services to the participant. The following elements must be included in the time sheet:

(1) the support worker's full name and individual provider number;

(2) the agency-provider's name and telephone numbers, when responsible for the CFSS service delivery plan;

(3) the participant's full name;

(4) the dates within the pay period established by the agency-provider or FMS provider, including month, day, and year, and arrival and departure times with a.m. or p.m. notations for days worked within the established pay period;

(5) the covered services provided to the participant on each date of service;

(6) the signature of the participant or the participant's representative and a statement that the participant's or participant's representative's signature is verification of the time sheet's accuracy;

(7) the signature of the support worker;

(8) any shared care provided, if applicable;

(9) a statement that it is a federal crime to provide false information on CFSS billings for medical assistance payments; and

(10) dates and location of participant stays in a hospital, care facility, or incarceration occurring within the established pay period.

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 the support worker:

(i) is not disqualified under section 245C.14; or

(ii) is disqualified, but 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) complete the basic standardized CFSS 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. CFSS 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;

(5) complete employer-directed training and orientation on the participant's individual needs;

(6) maintain the privacy and confidentiality of the participant; and

(7) not independently determine the medication dose or time for medications for the participant.

(b) The commissioner may deny or terminate a support worker's provider enrollment and provider number if the support worker:

(1) does not meet the requirements in paragraph (a);

(2) fails to provide the authorized services required by the 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 by 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 310 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.

(e) CFSS qualify for an enhanced rate or budget if the support worker providing the services:

(1) provides services, within the scope of CFSS described in subdivision 7, to a participant who qualifies for ten or more hours per day of CFSS; and

(2) satisfies the current requirements of Medicare for training and competency or competency evaluation of home health aides or nursing assistants, as provided in the Code of Federal Regulations, title 42, section 483.151 or 484.36, or alternative state-approved training or competency requirements. This paragraph expires upon the effective date of paragraph (f).

(f) Effective January 1, 2026, or upon federal approval, whichever is later, CFSS qualify for an enhanced rate or budget if the support worker providing the services:

(1) provides services, within the scope of CFSS described in subdivision 7, to a participant who qualifies for ten or more hours per day of CFSS; and

(2) satisfies the current requirements of Medicare for training and competency or competency evaluation of home health aides or nursing assistants, as provided in the Code of Federal Regulations, title 42, section 483.151 or 484.36, or alternative state-approved training or competency requirements.

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 provider 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 provider has been continuously enrolled as a CFSS agency-provider or FMS provider 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 provider to which the support worker is transferring;

(4) the support worker has been continuously enrolled with the former CFSS agency-provider or FMS provider 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 duties.** Consultation services is a required service that includes:

(1) entering into a written agreement with the participant, participant's representative, or legal representative that includes but is not limited to the details of services, service delivery methods, dates of services, and contact information;

(2) providing an initial and annual orientation to CFSS information and policies, including selecting a service model;

(3) assisting with accessing FMS providers or agency-providers;

(4) providing assistance with the development, implementation, management, documentation, and evaluation of the person-centered CFSS service delivery plan;

(5) maintaining documentation of the approved CFSS service delivery plan;

(6) distributing copies of the final CFSS service delivery plan to the participant and to the agency-provider or FMS provider, case manager or care coordinator, and other designated parties;

(7) assisting to fulfill responsibilities and requirements of CFSS, including modifying CFSS service delivery plans and changing service models;

(8) if requested, providing consultation on recruiting, selecting, training, managing, directing, supervising, and evaluating support workers;

(9) evaluating services upon receiving information from an FMS provider indicating spending or participant employer concerns;

(10) reviewing the use of and access to informal and community supports, goods, or resources;

(11) a semiannual review of services if the participant does not have a case manager or care coordinator and when the support worker is a paid parent of a minor participant or the participant's spouse;

(12) collecting and reporting of data as required by the department;

(13) providing the participant with a copy of the participant protections under subdivision 20 at the start of consultation services;

(14) providing assistance to resolve issues of noncompliance with the requirements of CFSS;

(15) providing recommendations to the commissioner for changes to services when support to participants to resolve issues of noncompliance have been unsuccessful; and

(16) other duties as assigned by the commissioner.

Subd. 17a. **Consultation services provider qualifications and requirements.** Consultation services providers must meet the following qualifications and requirements:

(1) meet the requirements under subdivision 10, paragraph (a), excluding clauses (4) and (5);

(2) be under contract with the department and enrolled as a Minnesota health care program provider;

(3) not be the FMS provider, the lead agency, or the CFSS or home and community-based services waiver vendor or agency-provider to the participant;

(4) meet the service standards as established by the commissioner;

(5) have proof of surety bond coverage. Upon new enrollment, or if the consultation service provider's Medicaid revenue in the previous calendar year is less than or equal to $300,000, the consultation service 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 consultation service provider must purchase a surety bond of $100,000. The surety bond must be in a form approved by the commissioner, must be purchased new annually, and must allow for recovery of costs and fees in pursuing a claim on the bond. Any action to obtain monetary recovery or sanctions from a surety bond must occur within six years from the date the debt is affirmed by a final agency decision. An agency decision is final when the right to appeal the debt has been exhausted or the time to appeal has expired under section 256B.064;

(6) employ lead professional staff with a minimum of two years of experience in providing services such as support planning, support broker, case management or care coordination, or consultation services and consumer education to participants using a self-directed program using FMS under medical assistance;

(7) report maltreatment as required under chapter 260E and section 626.557;

(8) comply with medical assistance provider requirements;

(9) understand the CFSS program and its policies;

(10) be knowledgeable about self-directed principles and the application of the person-centered planning process;

(11) have general knowledge of the FMS provider duties and the vendor fiscal/employer agent 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

(12) 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 are 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 costs 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 CFSS service delivery plan and as required under subdivisions 11b and 14;

(2) be provided or arranged for by the agency-provider under subdivision 11, or purchased by the participant employer under the budget model as identified in subdivision 13;

(3) be delivered by an individual competent to perform, teach, or assign the tasks, including health-related tasks, identified in the plan through education, training, and work experience relevant to the person's assessed needs; and

(4) 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 and condition, 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 and condition;

(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 at 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 CFSS service delivery plan; and

(4) the activities to evaluate CFSS services and ensure support worker competency described in subdivisions 11a and 11b.

(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 the limit set by the commissioner per annual service agreement, unless approved by the department.

Subd. 18b. **Worker training and development services; remote visits.** (a) Except as provided in paragraph (b), the worker training and development services specified in subdivision 18a, paragraph (c), clauses (3) and (4), may be provided to recipients with chronic health conditions or severely compromised immune systems via two-way interactive audio and visual telecommunications if, at the recipient's request, the recipient's primary health care provider:

(1) determines that remote worker training and development services are appropriate; and

(2) documents the determination under clause (1) in a statement of need or other document that is subsequently included in the recipient's CFSS service delivery plan.

(b) The worker training and development services specified in subdivision 18a, paragraph (c), clause (3), provided at the start of services or the start of employment of a new support worker must not be conducted via two-way interactive audio and visual telecommunications.

(c) Notwithstanding any other provision of law, a CFSS service delivery plan developed or amended via remote worker training and development services may be executed by electronic signature.

(d) A recipient may request to return to in-person worker training and development services at any time.

[See Note.]

Subd. 19. MS 2014 [Repealed by amendment, 2015 c 78 art 6 s 22]

Subd. 20. **Participant protections.** (a) All CFSS participants have the protections identified in this subdivision.

(b) Participants or participants' representatives 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 information must be provided by the consultation services provider at the time of the initial or annual orientation to CFSS, at the time of reassessment, or when requested by the participant or participant's representative. This information must explain:

(1) person-centered planning;

(2) the range and scope of participant choices, including the differences between the agency-provider model and the budget model, available CFSS providers, and other services available in the community to meet the participant's needs;

(3) the process for changing plans, services, and budgets;

(4) identifying and assessing appropriate services; and

(5) risks to and responsibilities of the participant under the budget model.

(c) The consultation services provider must ensure that the participant chooses freely between the agency-provider model and the budget model and among available agency-providers and that the participant may change agency-providers after services have begun.

(d) 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.

(e) 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.

(f) If all or part of a CFSS service delivery plan is denied approval by the lead agency, the lead agency must provide a notice that describes the basis of the denial.

Subd. 20a. **Notice of participant rights from an agency-provider.** A participant receiving CFSS from an agency-provider has the rights identified in this subdivision and in subdivisions 20b and 20c. The agency-provider must:

(1) within five working days of service initiation and annually thereafter, provide each participant or participant's representative with a written notice that identifies the service recipient rights in subdivisions 20b and 20c, and an explanation of those rights;

(2) make reasonable accommodations to provide this information in other formats or languages as needed to facilitate understanding of the rights by the participant and the participant's legal representative, if any;

(3) maintain documentation of the receipt of a copy and an explanation of the rights by the participant or participant's representative; and

(4) ensure the exercise and protection of the participant's rights in the services provided by the agency-provider and as authorized in the CFSS service delivery plan.

Subd. 20b. **Service-related rights under an agency-provider.** A participant receiving CFSS from an agency-provider has service-related rights to:

(1) participate in and approve the initial development and ongoing modification and evaluation of CFSS services provided to the participant;

(2) refuse or terminate services and be informed of the consequences of refusing or terminating services;

(3) before services are initiated, be told the limits to the services available from the agency-provider, including the agency-provider's knowledge, skill, and ability to meet the participant's needs identified in the CFSS service delivery plan;

(4) a coordinated transfer of services when there will be a change in the agency-provider;

(5) before services are initiated, be told what the agency-provider charges for the services;

(6) before services are initiated, be told to what extent payment may be expected from health insurance, public programs, or other sources, if known; and what charges the participant may be responsible for paying;

(7) receive services from an individual who is competent and trained, who has professional certification or licensure, as required, and who meets additional qualifications identified in the participant's CFSS service delivery plan;

(8) have the participant's preferences for support workers identified and documented, and have those preferences met when possible; and

(9) before services are initiated, be told the choices that are available from the agency-provider for meeting the participant's assessed needs identified in the CFSS service delivery plan, including but not limited to which support worker staff will be providing services, the proposed frequency and schedule of visits, and any agreements for shared services.

Subd. 20c. **Protection-related rights under an agency-provider or through an FMS provider.** A participant receiving CFSS from an agency-provider or through an FMS provider has protection-related rights to:

(1) access records and recorded information about the participant in accordance with applicable state and federal law, regulation, or rule;

(2) know how to contact an individual associated with the agency-provider or FMS provider who is responsible for handling problems, know the agency-provider's or FMS provider's policies and procedures for resolving grievances, and have the agency-provider or FMS provider investigate and attempt to resolve the grievance or complaint;

(3) know the name, telephone number, and address of the state or county agency, the Office of the Ombudsman for Long-Term Care, and the state protection and advocacy service to contact for additional information or assistance;

(4) have personal, financial, and medical information kept private, and be advised of disclosure of this information by the agency-provider or FMS provider and the agency-provider's or FMS provider's policies and procedures regarding data privacy;

(5) be treated with courtesy and respect, and have the participant's property treated with respect;

(6) be free from maltreatment; and

(7) assert these rights personally, or have them asserted by the participant's representative or by anyone authorized by the participant to act on behalf of the participant, without retaliation.

Subd. 21. **Development and Implementation Council.** The commissioner shall establish a Development and Implementation Council of which the majority of members are participants with disabilities, elderly participants, 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.

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) The commissioner shall develop performance measures and data reporting requirements in consultation with the council established in subdivision 21.

Subd. 23. **Commissioner's access.** (a) 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, consultation services provider, or FMS provider's office during regular business hours and

to documentation and records related to services provided and submission of claims for services provided. If the agency-provider, FMS provider, or consultation services provider denies the commissioner access to records, the provider's payment may be immediately suspended or the provider's enrollment may be terminated according to section 256B.064.

(b) The commissioner has the authority to request proof of compliance with laws, rules, and policies from agency-providers, consultation services providers, FMS providers, and participants.

(c) When relevant to an investigation conducted by the commissioner, the commissioner must be given access to the business office, documents, and records of the agency-provider, consultation services provider, or FMS provider, including records maintained in electronic format; participants served by the program; and staff during regular business hours. The commissioner must be given access without prior notice and as often as the commissioner considers necessary if the commissioner is investigating an alleged violation of applicable laws or rules. The commissioner may request and shall receive assistance from lead agencies and other state, county, and municipal agencies and departments. The commissioner's access includes being allowed to photocopy, photograph, and make audio and video recordings at the commissioner's expense.

Subd. 23a. **Sanctions; information for participants upon termination of services.** (a) The commissioner may withhold payment from the provider or suspend or terminate the provider enrollment number if the provider fails to comply fully with applicable laws or rules. The provider has the right to appeal the decision of the commissioner under section 256B.064.

(b) Notwithstanding subdivision 13, paragraph (e), if a participant employer fails to comply fully with applicable laws or rules, the commissioner may disenroll the participant from the budget model. A participant may appeal in writing to the department under section 256.045, subdivision 3, to contest the department's decision to disenroll the participant from the budget model.

(c) Agency-providers of CFSS services or FMS providers must meet the recipient protection requirements under section 256B.045 when subject to an administrative action or a serious operational event as defined in section 256B.045, subdivision 1.

Subd. 24. **CFSS agency-providers and FMS providers; background studies.** CFSS agency-providers and FMS 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 providers and those agencies seeking enrollment. "Managing employee" has the meaning given in Code of Federal Regulations, title 42, section 455.101. 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 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. MS 2014 [Repealed by amendment, 2015 c 78 art 6 s 22]

Subd. 26. **Oversight plan.** In consultation with the Development and Implementation Council described in subdivision 21 and other stakeholders, the commissioner shall develop recommendations for the oversight of CFSS.

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; 2015 c 78 art 6 s 22; 2016 c 158 art 1 s 136,137; 2019 c 54 art 2 s 40-42; 1Sp2019 c 9 art 5 s 70-75; 2020 c 83 art 1 s 70; 1Sp2020 c 2 art 8 s 99,100; 5Sp2020 c 3 art 10 s 2; 2021 c 30 art 13 s 58-81; 1Sp2021 c 7 art 13 s 49-54; 2022 c 98 art 17 s 18,19,26; 2023 c 59 art 1 s 6,7; 2023 c 61 art 1 s 51,52; 2024 c 80 art 1 s 96; art 2 s 74; 2024 c 108 art 1 s 19-27; 2024 c 115 art 16 s 34,41; 1Sp2025 c 3 art 17 s 11; 1Sp2025 c 9 art 2 s 38-48; 2026 c 88 art 1 s 136,137; 2026 c 121 art 1 s 5; art 4 s 30,31; art 9 s 40-45,61*

NOTE: Subdivision 18b, as added by Laws 2024, chapter 108, article 1, section 26, is effective upon community first services and supports implementation. The commissioner of human services shall notify the revisor of statutes upon CFSS implementation. Laws 2024, chapter 108, article 1, section 26, the effective date.

256B.8502 COMMUNITY FIRST SERVICES AND SUPPORTS; DEFINITIONS.

Subdivision 1. **Scope.** For the purposes of this section and sections 256B.85 and 256B.851, the terms in this section have the meanings given.

Subd. 2. **Activities of daily living or ADLs.** "Activities of daily living" or "ADLs" means:

(1) dressing, including assistance with choosing, applying, and changing clothing and applying 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. Grooming includes nail care, except for recipients who are diabetic or have poor circulation;

(3) bathing, including assistance with basic personal hygiene and skin care;

(4) eating, including assistance with hand washing and applying orthotics required for eating or feeding;

(5) transfers, including assistance with transferring the participant from one seating or reclining area to another;

(6) mobility, including assistance with ambulation and use of a wheelchair. Mobility does not include providing transportation for a participant;

(7) positioning, including assistance with positioning or turning a participant for necessary care and comfort; and

(8) toileting, including assistance with bowel or bladder elimination and care, transfers, mobility, positioning, feminine hygiene, use of toileting equipment or supplies, cleansing the perineal area, inspection of the skin, and adjusting clothing.

Subd. 3. **Additional revenue for shared services.** "Additional revenue for shared services" means the difference between the rate paid to an agency-provider for serving a single participant and the sum of the rates paid to an agency-provider for shared services provided to more than one recipient.

Subd. 4. **Agency-provider model.** "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.

Subd. 5. **Behavior.** "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.

Subd. 6. **Budget model.** "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) provider for a participant to directly employ support workers and purchase supports and goods.

Subd. 7. **Commissioner.** "Commissioner" means the commissioner of human services.

Subd. 8. **Community first services and supports or CFSS.** "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 section 256B.85, subdivision 7, clause (3), that replace the need for human assistance.

Subd. 9. **Community first services and supports delivery plan or CFSS service delivery plan.** "Community first services and supports service delivery plan" or "CFSS 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, as determined in section 256B.85, subdivision 8. Services and supports are based on the support plan identified in sections 256B.092, subdivision 1b, and 256S.10.

Subd. 10. **Complex health-related needs.** "Complex health-related needs" means an intervention listed in clauses (1) to (8) that has been ordered by a physician, advanced practice registered nurse, or physician's assistant and is specified in an assessment summary, 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;

(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.0651;

(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, advanced practice registered nurse, or physician's assistant 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.

Subd. 11. **Component value.** "Component value" means an underlying factor that is built into the rate methodology to calculate service rates and is part of the cost of providing services.

Subd. 12. **Consultation services.** "Consultation services" means assisting a participant in making informed choices about CFSS services in general and self-directed tasks in particular, and in developing a person-centered CFSS service delivery plan to achieve quality service outcomes.

Subd. 13. **Critical activities of daily living.** "Critical activities of daily living" means transferring, mobility, eating, and toileting.

Subd. 14. **Dependency.** "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 must 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.

Subd. 15. **Extended CFSS.** "Extended CFSS" means CFSS services and supports provided under CFSS that are included in the CFSS service delivery plan through one of the home and community-based services waivers and as approved and authorized under chapter 256S and sections 256B.092, subdivision 5, and

256B.49, which exceed the amount, duration, and frequency of the state plan CFSS services for participants. Extended CFSS excludes the purchase of goods.

Subd. 16. **Financial management services provider or FMS provider.** "Financial management services provider" or "FMS provider" means a qualified organization required for participants using the budget model under section 256B.85, subdivision 13, that is an enrolled provider with the department to provide vendor fiscal/employer agent financial management services (FMS).

Subd. 17. **Health-related procedures and tasks.** "Health-related procedures and tasks" means procedures and tasks related to the specific assessed health needs of a participant that can be taught or assigned by a state-licensed health care or mental health professional and performed by a support worker.

Subd. 18. **Individual provider support worker.** "Individual provider support worker" means a support worker who is an individual provider as defined in section 256B.0711, subdivision 1.

Subd. 19. **Instrumental activities of daily living.** "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, including traveling to medical appointments. For purposes of this subdivision, traveling includes driving and accompanying the recipient in the recipient's chosen mode of transportation and according to the individual CFSS service delivery plan.

Subd. 20. **Lead agency.** "Lead agency" has the meaning given in section 256B.0911, subdivision 10.

Subd. 21. **Legal representative.** "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.

Subd. 22. **Level I behavior.** "Level I behavior" means physical aggression toward self or others or destruction of property that requires the immediate response of another person.

Subd. 23. **Medication assistance.** "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 must 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.

Subd. 24. **Participant.** "Participant" means a person who is eligible for CFSS.

Subd. 25. **Participant's representative.** "Participant's representative" means a parent, family member, advocate, or other adult authorized by the participant or participant's legal representative, if any, to serve as a representative in connection with the provision of CFSS. If the participant is unable to assist in the selection of a participant's representative, the legal representative shall appoint one.

Subd. 26. **Payment rate or rate.** "Payment rate" or "rate" means reimbursement to an eligible provider for services provided to a qualified individual based on an approved service authorization.

Subd. 27. **Person-centered planning process.** "Person-centered planning process" means a process that is directed by the participant to plan for CFSS services and supports.

Subd. 28. **Service budget.** "Service budget" means the authorized dollar amount used for the budget model or for the purchase of goods.

Subd. 29. **Shared services.** "Shared services" means the provision of CFSS services by the same CFSS support worker to two or three participants who voluntarily enter into a written agreement to receive services at the same time, in the same setting, and through the same agency-provider or FMS provider.

Subd. 30. **Support worker.** "Support worker" means a qualified and trained employee of the agency-provider as required by section 256B.85, subdivision 11b, or of the participant employer under the budget model as required by section 256B.85, subdivision 14, who has direct contact with the participant and provides services as specified within the participant's CFSS service delivery plan.

Subd. 31. **Unit.** "Unit" means the increment of service based on hours or minutes identified in the service agreement.

Subd. 32. **Vendor fiscal employer agent.** "Vendor fiscal employer agent" means an agency that provides financial management services.

Subd. 33. **Wages and benefits.** "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.

Subd. 34. **Wages and wage-related costs.** "Wages and wage-related costs" means increased wages and any corresponding increase in the employer's or participant employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation premiums, and contributions to employee retirement accounts when the contribution is a function of wages.

Subd. 35. **Worker training and development.** "Worker training and development" means services provided according to section 256B.85, subdivision 18a, for developing workers' skills as required by the participant's individual CFSS service 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.

History: *2013 c 108 art 7 s 49; 2014 c 275 art 1 s 69; 2014 c 312 art 26 s 4; 2019 c 54 art 2 s 40; 2020 c 83 art 1 s 70; 2021 c 30 art 13 s 59; 1Sp2021 c 7 art 13 s 49,55; 2022 c 98 art 17 s 18,26; 2024 c 108 art 1 s 19; 1Sp2025 c 9 art 2 s 38; 2026 c 121 art 9 s 46,61*

256B.851 COMMUNITY FIRST SERVICES AND SUPPORTS; PAYMENT RATES.

Subdivision 1. **Application.** (a) The payment methodologies in this section apply to:

(1) community first services and supports (CFSS), extended CFSS, and enhanced rate CFSS under section 256B.85; and

(2) personal care assistance services under section 256B.0625, subdivisions 19a and 19c; extended personal care assistance services as defined in section 256B.0659, subdivision 1; and enhanced rate personal care assistance services under section 256B.0659, subdivision 17a.

(b) This section does not change existing personal care assistance program or community first services and supports policies and procedures.

Subd. 2. **Definitions.** (a) [Repealed by amendment, 2026 c 121 art 9 s 61]

(b) [Renumbered 256B.8502, subd 7]

(c) [Renumbered 256B.8502, subd 11]

(d) [Renumbered 256B.8502, subd 26]

Subd. 3. **Payment rates; base wage index.** When initially establishing the base wage component values, the commissioner must use the Minnesota-specific median wage for the standard occupational classification (SOC) codes published by the Bureau of Labor Statistics in the edition of the Occupational Handbook published in March 2021. The commissioner must calculate the base wage component values as follows for:

(1) personal care assistance services, CFSS, extended personal care assistance services, and extended CFSS. The base wage component value equals the median wage for personal care aide (SOC code 31-1120);

(2) enhanced rate personal care assistance services and enhanced rate CFSS. The base wage component value equals the product of median wage for personal care aide (SOC code 31-1120) and the value of the enhanced rate under section 256B.0659, subdivision 17a; and

(3) qualified professional services and CFSS worker training and development. The base wage component value equals the sum of 70 percent of the median wage for registered nurse (SOC code 29-1141), 15 percent of the median wage for health care social worker (SOC code 21-1099), and 15 percent of the median wage for social and human service assistant (SOC code 21-1093).

Subd. 4. **Payment rates; total wage index.** (a) The commissioner must multiply the base wage component values in subdivision 3 by one plus the appropriate competitive workforce factor. The product is the total wage component value.

(b) For personal care assistance services, CFSS, extended personal care assistance services, extended CFSS, enhanced rate personal care assistance services, and enhanced rate CFSS, the initial competitive workforce factor is 4.7 percent.

(c) For qualified professional services and CFSS worker training and development, the competitive workforce factor is zero percent.

Subd. 5. **Payment rates; component values.** (a) The commissioner must use the following component values:

(1) employee vacation, sick, and training factor, 8.71 percent;

(2) employer taxes and workers' compensation factor, 11.56 percent;

(3) employee benefits factor, 12.04 percent;

(4) client programming and supports factor, 2.30 percent;

(5) program plan support factor, 7.00 percent;

(6) general business and administrative expenses factor, 13.25 percent;

(7) program administration expenses factor, 2.90 percent; and

(8) absence and utilization factor, 3.90 percent.

(b) Effective January 1, 2025, for purposes of implementation, the commissioner shall use the following implementation components:

(1) personal care assistance services and CFSS: 92.08 percent;

(2) enhanced rate personal care assistance services and enhanced rate CFSS: 92.08 percent; and

(3) qualified professional services and CFSS worker training and development: 92.08 percent. This paragraph expires upon the effective date of subdivision 5a.

(c) The commissioner shall use the following worker retention components:

(1) for workers who have provided fewer than 1,001 cumulative hours in personal care assistance services or CFSS, the worker retention component is zero percent;

(2) for workers who have provided between 1,001 and 2,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 2.17 percent;

(3) for workers who have provided between 2,001 and 6,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 4.36 percent;

(4) for workers who have provided between 6,001 and 10,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 7.35 percent; and

(5) for workers who have provided more than 10,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 10.81 percent. This paragraph expires upon the effective date of subdivision 5b.

(d) The commissioner shall define the appropriate worker retention component under subdivision 5b or 5c based on the total number of units billed for services rendered by the individual provider since July 1, 2017. The worker retention component must be determined by the commissioner for each individual provider and is not subject to appeal.

Subd. 5a. **Payment rates; implementation components.** Effective January 1, 2026, or upon federal approval, whichever is later, for purposes of implementation, the commissioner shall use the following implementation components:

(1) personal care assistance services and CFSS: 92.20 percent;

(2) enhanced rate personal care assistance services and enhanced rate CFSS: 92.20 percent; and

(3) qualified professional services and CFSS worker training and development: 92.20 percent.

Subd. 5b. **Payment rates; worker retention component.** Effective January 1, 2026, or upon federal approval, whichever is later, the commissioner shall use the following worker retention components:

(1) for workers who have provided fewer than 1,001 cumulative hours in personal care assistance services or CFSS, the worker retention component is zero percent;

(2) for workers who have provided between 1,001 and 2,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 4.05 percent;

(3) for workers who have provided between 2,001 and 6,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 6.24 percent;

(4) for workers who have provided between 6,001 and 10,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 9.23 percent; and

(5) for workers who have provided more than 10,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 12.69 percent.

Subd. 5c. **Payment rates; enhanced worker retention component.** Effective January 1, 2027, or upon federal approval, whichever is later, the commissioner shall use the following worker retention components if a worker has completed either the orientation for individual providers offered through the Home Care Orientation Trust or an orientation defined and offered by the commissioner:

(1) for workers who have provided fewer than 1,001 cumulative hours in personal care assistance services or CFSS, the worker retention component is 1.88 percent;

(2) for workers who have provided between 1,001 and 2,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 5.92 percent;

(3) for workers who have provided between 2,001, and 6,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 8.11 percent;

(4) for workers who have provided between 6,001 and 10,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 11.10 percent; and

(5) for workers who have provided more than 10,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 14.56 percent.

Subd. 6. **Payment rates; rate determination.** (a) The commissioner must determine the rate for personal care assistance services, CFSS, extended personal care assistance services, extended CFSS, enhanced rate personal care assistance services, enhanced rate CFSS, qualified professional services, and CFSS worker training and development as follows:

(1) multiply the appropriate total wage component value calculated in subdivision 4 by one plus the employee vacation, sick, and training factor in subdivision 5;

(2) for program plan support, multiply the result of clause (1) by one plus the program plan support factor in subdivision 5;

(3) for employee-related expenses, add the employer taxes and workers' compensation factor in subdivision 5 and the employee benefits factor in subdivision 5. The sum is employee-related expenses. Multiply the product of clause (2) by one plus the value for employee-related expenses;

(4) for client programming and supports, multiply the product of clause (3) by one plus the client programming and supports factor in subdivision 5;

(5) for administrative expenses, add the general business and administrative expenses factor in subdivision 5, the program administration expenses factor in subdivision 5, and the absence and utilization factor in subdivision 5;

(6) divide the result of clause (4) by one minus the result of clause (5). The quotient is the hourly rate;

(7) multiply the hourly rate by the appropriate implementation component under subdivision 5 or 5a. This is the adjusted hourly rate; and

(8) divide the adjusted hourly rate by four. The quotient is the total adjusted payment rate.

(b) In processing personal care assistance provider agency and CFSS provider agency claims, the commissioner shall incorporate the applicable worker retention components specified in subdivision 5, 5b, or 5c, by multiplying one plus the total adjusted payment rate by the appropriate worker retention component under subdivision 5, 5b, or 5c.

(c) The commissioner must publish the total final payment rates.

Subd. 7. **Treatment of rate adjustments provided outside of cost components.** Any rate adjustments applied to the service rates calculated under this section outside of the cost components and rate methodology specified in this section, including but not limited to those implemented to enable participant-employers and provider agencies to meet the terms and conditions of any collective bargaining agreement negotiated under chapter 179A, shall be applied as changes to the value of component values, implementation components, or worker retention components in subdivisions 5 to 5c.

[See Note.]

Subd. 7a. **Budget determinations.** Effective January 1, 2026, the commissioner shall increase the authorized amount for the CFSS budget model of those CFSS participant-employers employing individual providers who have provided more than 1,000 hours of services. Effective January 1, 2027, the commissioner must increase the authorized amount for the CFSS budget model of those CFSS participant-employers employing individual providers who have provided more than 1,000 hours of services and providers who have completed the orientation offered by the Home Care Orientation Trust or an orientation defined and offered by the commissioner. The commissioner shall determine the amount and method of the authorized amount increase.

[See Note.]

Subd. 8. **Personal care provider agency; required reporting of cost data; training.** (a) As determined by the commissioner and in consultation with stakeholders, agencies enrolled to provide services with rates determined under this section must submit requested cost data to the commissioner. The commissioner may request cost data, including but not limited to:

(1) worker wage costs;

(2) benefits paid;

(3) supervisor wage costs;

(4) executive wage costs;

(5) vacation, sick, and training time paid;

(6) taxes, workers' compensation, and unemployment insurance costs paid;

(7) administrative costs paid;

(8) program costs paid;

(9) transportation costs paid;

(10) staff vacancy rates; and

(11) other data relating to costs required to provide services requested by the commissioner.

(b) At least once in any three-year period, a provider must submit the required cost data for a fiscal year that ended not more than 18 months prior to the submission date. The commissioner must provide each provider a 90-day notice prior to its submission due date. The commissioner may review report submissions for inaccurate, inconclusive, incomplete, or otherwise deficient data and may remove the report from submitted status for further verification. If a provider fails to submit required cost data, the commissioner must provide notice to a provider that has not provided required cost data 30 days after the required submission date and a second notice to a provider that has not provided required cost data 60 days after the required submission date. The commissioner must temporarily suspend payments to a provider if the commissioner has not received required cost data 90 days after the required submission date. The commissioner must make withheld payments when the required cost data is received and reviewed for compliance by the commissioner.

(c) The commissioner must conduct a random validation of data submitted under this subdivision to ensure data accuracy. A provider selected to validate the provider's cost reports must respond to the commissioner within 30 days with the requested financial documentation. If a provider fails to respond to the commissioner with the requested information within 30 days, the commissioner must temporarily suspend payments. The commissioner must resume payments once the requested documentation is received. If a provider is unable to validate the provider's costs with supporting documentation, the commissioner must require the provider to participate in the random validation the next year that the commissioner selects providers to report their costs. The commissioner shall analyze cost documentation in paragraph (a) and provide recommendations for adjustments to cost components.

(d) The commissioner, in consultation with stakeholders, must develop and implement a process for providing training and technical assistance necessary to support provider submission of cost data required under this subdivision.

Subd. 9. **Analysis of costs; recommendations.** (a) The commissioner shall evaluate on an ongoing basis whether the base wage component values and component values in this section appropriately address the cost to provide the service.

(b) The commissioner shall analyze cost data submitted by provider agencies under subdivision 8 and report recommendations on component values, updated base wage component values, and competitive workforce factors to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over human services policy and finance every two years beginning August 1, 2026. The commissioner shall release cost data in an aggregate form, and cost data from individual providers shall not be released except as provided for in current law.

(c) Beginning August 1, 2024, and every two years thereafter, 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 policy and finance to update the base wage index in subdivision 3, the competitive workforce factors in subdivision 4, and the component values in subdivision 5 using the most recently available data. In making recommendations, the commissioner shall:

(1) make adjustments to the competitive workforce factor toward the percent difference between:

(i) the median wage for personal care aide (SOC code 31-1120); and

(ii) the weighted average wage for all other SOC codes with the same Bureau of Labor Statistics classifications for education, experience, and training required for job competency;

(2) not recommend an increase or decrease of the competitive workforce factor from its previous value of more than three percentage points;

(3) not recommend a competitive workforce factor of less than zero;

(4) make adjustments to the value of the base wage components based on the most recently available federal wage data; and

(5) make adjustments to any component values affected by inflation, including but not limited to the client programming and supports factor.

Subd. 10. **Payment rate evaluation; reports required.** The commissioner must assess the long-term impacts of the rate methodology implementation on staff providing services with rates determined under this section, including but not limited to measuring changes in wages, benefits provided, hours worked, and retention. The commissioner must publish evaluation findings in a report to the legislature by August 1, 2028, and once every two years thereafter.

Subd. 11. **Self-directed services workforce.** Nothing in this section limits the commissioner's authority over terms and conditions for individual providers in covered programs as defined in section 256B.0711. The commissioner's authority over terms and conditions for individual providers in covered programs remains 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. A change in the rate for services within the covered programs defined in section 256B.0711 does not constitute a change in a term or condition for individual providers in covered programs and is not subject to the state's obligation to meet and negotiate under chapter 179A.

History: *1Sp2021 c 7 art 13 s 55; 2023 c 61 art 1 s 53-55; 1Sp2025 c 9 art 2 s 49-55; 2026 c 95 art 4 s 30; 2026 c 121 art 9 s 61*

NOTE: The amendments to subdivision 7 by Laws 2025, First Special Session chapter 9, article 2, section 54, are effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2025, First Special Session chapter 9, article 2, section 54, the effective date.

NOTE: Subdivision 7a, as added by Laws 2025, First Special Session chapter 9, article 2, section 55, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2025, First Special Session chapter 9, article 2, section 55, the effective date.