CHAPTER 9505
DEPARTMENT OF HUMAN SERVICES
HEALTH CARE PROGRAMS

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9505.0323 MENTAL HEALTH SERVICES.

Subpart 1 **Definitions.** For this part, the following terms have the meanings given them

[For text of items A to F, see M R]

G "Day treatment" or "day treatment program" means a structured program of treatment and care provided to persons in

[For text of subitems (1) and (2), see M R]

(3) an entity that is under contract with the county to operate a program that meets the requirements of Minnesota Statutes, section 245 4712, subdivision 2, and 245 4884, subdivision 2, and parts 9505 0170 to 9505 0475

Day treatment consists of group psychotherapy and other intensive therapeutic services that are provided by a multidisciplinary staff The services are aimed at stabilizing the client's mental health status, providing mental health services, and developing and improving the client's independent living and socialization skills The goal of day treatment is to reduce or relieve the effects of mental illness and provide training to enable the client to live in the community Day treatment services are not a part of inpatient or residential treatment services Day treatment services are distinguished from day care by their structured therapeutic program of psychotherapy services

[For text of items H to Z, see M R]

[For text of subps 2 to 4, see M R]

Subp 5 **Extension of time available to complete a recipient's diagnostic assessment.** The two-hour time limit in subpart 4, item C, for completing the diagnostic assessment does not apply if the mental health professional conducting the diagnostic assessment documents in the recipient's record that the recipient has a condition specified in item A and a circumstance specified in item B, C, or D, is present In this event, medical assistance will pay for the recipient's diagnostic assessment of up to eight hours in length and the mental health professional conducting the diagnostic assessment must develop the recipient's individual treatment plan The mental health professional conducting the diagnostic assessment must document in the recipient's record the circumstances requiring the extended time For purposes of this subpart, "initial diagnostic assessment" refers to the first time that a recipient receives a diagnostic assessment of a set of symptoms indicating a possible mental illness

A The recipient has a diagnosis of mental illness and is

(1) A person with mental retardation as defined in part 9525 0016, subpart 2, or a related condition as defined in Minnesota Statutes, section 252 27, subdivision 1a

[For text of subitems (2) to (6), see M R]

[For text of item B, see M R]

C An extension of the time for an initial diagnostic assessment has been authorized by the case manager according to parts 9525 0004 to 9525 0036

[For text of item D, see M R]

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[For text of subps 6 to 9, see M R]

Subp 10 **Limitations on medical assistance payment for psychotherapy sessions.** There are limitations on medical assistance payment for psychotherapy sessions as specified in the list of health services published according to Minnesota Statutes, section 256B 0625, subdivision 25

[For text of subps 11 to 26, see M.R]

Subp. 27 **Excluded services.** The mental health services in items A to S are not eligible for medical assistance payment

[For text of items A to G, see M R]

H a service provided to a resident of an intermediate care facility for the mentally retarded if the service is not specified on the resident's individual service plan as set forth in parts 9525 0004 to 9525 0036,

[For text of items I to S, see M R]

[For text of subps 28 to 32, see M R]

Statutory Authority: *MS s 256B 092*

History: *18 SR 2244*

9505.0415 LONG–TERM CARE FACILITIES; LEAVE DAYS.

[For text of subps 1 to 5, see M R]

Subp 6 **Payment limitations on number of leave days for therapeutic leave.** Payment for leave days for therapeutic leave is limited to the number of days as in items A to D

A recipients receiving skilled nursing facility services as provided in part 9505.0420, subpart 2, 36 leave days per calendar year,

B recipients receiving intermediate care facility services as provided in part 9505 0420, subpart 3, 36 leave days per calendar year,

C recipients receiving intermediate care facility, mentally retarded services as provided in part 9505 0420, subpart 4, 72 leave days per calendar year In addition to the number of leave days specified in this item, the commissioner may approve up to 48 additional therapeutic leave days per calendar year for family activities if

(1) the recipient or recipient's legal representative requests additional therapeutic leave days,

(2) the case manager recommends that the leave is consistent with the goals of the recipient's individual service plan as defined in Minnesota Statutes, section 256B 092, subdivision 1b,

(3) an evaluation by the case manager shows that home and community–based services and other alternative services are not feasible; and

(4) all other state and federal requirements relating to therapeutic leave days are met,

D recipients residing in a long–term care facility that has a license to provide services for the physically handicapped as provided in parts 9570 2000 to 9570 3600, 72 leave days per calendar year

[For text of subp 7, see M R]

Statutory Authority: *MS s 256B 04*

History: *19 SR 1227*

9505.2395 DEFINITIONS.

[For text of subpart 1, see M R]

Subp 2 **Adult day care services.** "Adult day care services" means services provided to alternative care grant clients by adult day care programs established under Minnesota Statutes, sections 245A.01 to 245A 16, including adult day care centers licensed under parts 9555 9600 to 9555 9730

[For text of subp 3, see M R]

Subp 4 **Alternative care grant or ACG.** "Alternative care grant" or "ACG" means funds allocated to a local agency by the commissioner under Minnesota Statutes, section 256B 0913, to pay for alternative care services

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[For text of subps 5 to 24, see M R]

Subp 25 **Individual service plan.** "Individual service plan" means the written plan of a community service or a combination of community services designed to meet the health and social needs of an applicant or nursing home resident screened according to part 9505 2430 The individual service plan is the plan of care referred to in Minnesota Statutes, section 256B 092

[For text of subps 26 to 29, see M R]

Subp 30 **Mental illness.** "Mental illness" means an illness as defined in Minnesota Statutes, section 245 462, subdivision 20, paragraph (a)

[For text of subps 31 to 34, see M R]

Subp 35 **Person with mental retardation or related conditions.** "Person with mental retardation or related conditions" has the meaning given to "person" under part 9525 0004, subpart 19

[For text of subp 36, see M R]

Subp 37 **Preadmission screening.** "Preadmission screening" means the activities performed by a preadmission screening team under Minnesota Statutes, section 256B 0911, and parts 9505 2390 to 9505 2500 This definition does not include the activities of teams authorized under Minnesota Statutes, section 256B 092, and established in parts 9525 0004 to 9525 0036 and under the Minnesota Comprehensive Mental Health Act, Minnesota Statutes, sections 245 461 to 245 486

[For text of subp 38, see M R.]

Subp 39 **Preadmission screening team.** "Preadmission screening team" means the team authorized in Minnesota Statutes, section 256B 0911, and required by part 9505 2410, to assess the financial, health, and social needs of an applicant or a nursing home resident.

[For text of subps 40 to 47, see M.R]

Subp 48 **Resident class.** "Resident class" refers to the case mix classification required under Minnesota Statutes, section 256B 0911, and assigned to a person as required under parts 9549 0058, subpart 2, and 9549 0059

[For text of subps 49 to 56, see M R]

Statutory Authority: *MS s 256B 092*

History: *18 SR 2244*

9505.2400 PREADMISSION SCREENING REQUIREMENT.

Subpart 1 **Coverage.** The preadmission screening team established by the local agency must complete the preadmission screening of all applicants except individuals who are exempt under subpart 2 and the preadmission screening of current nursing home residents who request a screening The preadmission screening team shall complete the screening as specified in part 9505 2425, except in the cases of persons with mental retardation or related conditions Persons with mental retardation or related conditions must be provided services according to parts 9525 0004 to 9525 0036 Persons with mental illness must be provided services according to the Minnesota Comprehensive Mental Health Act, Minnesota Statutes, sections 245 461 to 245.486

Subp. 2 **Exemptions.** The following individuals are exempt from the requirement of subpart 1.

[For text of items A to H, see M R]

I. an applicant who enters a nursing home administered by and for the adherents of a recognized church or religious denomination described in Minnesota Statutes, section 256B 0911, and

[For text of item J, see M R]

Statutory Authority: *MS s 256B 092*

History: *18 SR 2244*

9505.2425 SCREENING AND ASSESSMENT PROCEDURES REQUIRED DURING PREADMISSION SCREENING.

[For text of subps 1 and 2, see M R]

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Subp 3 **Information given to person being screened by screening team during preadmission screening.** The preadmission screening team must give the person being screened or the person's representative the form or forms supplied by the commissioner containing the information specified in items A to E

A the purpose of the preadmission screening under Minnesota Statutes, section 256B 0911, and the alternative care grant program under Minnesota Statutes, section 256B 0913,

[For text of items B and C, see M R]

D the person's right to appeal the preadmission screening team's recommendation under part 9505 2500 and Minnesota Statutes, sections 256 045, subdivision 3 and 256B 0911, subdivision 7, and

[For text of item E, see M R]

[For text of subp 4, see M R]

Subp 5 **Preadmission screening team recommendations.** After completing the assessment form required in subpart 1, the preadmission screening team must offer the person being screened or the person's representative the most cost effective alternatives available to meet the person's needs and must recommend one of the choices specified in items A to E

[For text of items A to C, see M R]

D A preadmission screening team that has reason to believe that a person being screened has or may have a diagnosis of mental retardation or related conditions must refer the person for services including screening, development of the individual service plan, and case management according to parts 9525 0004 to 9525 0036

[For text of item E, see M R]

[For text of subps 6 to 12, see M R]

Subp 13 **Resident class assessment.** The preadmission screening team must complete the resident class assessment of the applicant required under parts 9549 0058 and 9549 0059 for an applicant who is not exempt from preadmission screening under part 9505 2400, subpart 2, or 9549 0059, subpart 1, item A, subitem (2) The resident class assessment shall be completed concurrently with preadmission screening performed within the time requirements of part 9505 2420

[For text of subp 14, see M R]

Statutory Authority: *MS s 256B 092*

History: *18 SR 2244*

9505.3015 DEFINITIONS.

[For text of subps 1 and 2, see M R]

Subp 3 **Adult day care services.** "Adult day care services" means services provided to recipients by adult day care centers licensed under parts 9555 9600 to 9555 9730 and adult day care family homes established under Minnesota Statutes, sections 245A 01 to 245A 16

[For text of subps 4 to 30, see M R]

Subp 31 **Person with mental retardation or a related condition.** "Person with mental retardation or a related condition" has the meaning given to "person" in part 9525 0004, subpart 19

[For text of subps 32 and 33, see M R]

Subp 34 **Preadmission screening or screening.** "Preadmission screening" or "screening" means the activities established under Minnesota Statutes, section 256B 0911, and specified in part 9505 3025

[For text of subps 35 to 37, see M R]

Subp 38 **Public health nursing service.** "Public health nursing service" means the nursing program provided by a board of health under Minnesota Statutes, chapter 145A

[For text of subps 39 to 53, see M R]

Statutory Authority: *MS s 256B.092*

History: *18 SR 2244*

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DEPARTMENT HEALTH CARE PROGRAM PARTICIPATION REQUIREMENTS FOR VENDORS AND HEALTH MAINTENANCE ORGANIZATIONS

9505.5200 PURPOSE.

Parts 9505 5200 to 9505 5240 establish requirements for participation by vendors and health maintenance organizations in the medical assistance program, general assistance medical care program, and MinnesotaCare as a condition of participating in other state health care programs

Statutory Authority: *MS s 256B 0644*

History: *18 SR 2651*

9505.5210 DEFINITIONS.

Subpart 1. **Applicability.** For the purposes of parts 9505 5200 to 9505 5240, the terms in this part have the meanings given them

Subp 2 **Capitation rate.** "Capitation rate" means a method of payment for health care services under which a monthly per person rate is paid on a prospective basis to a health plan

Subp 3 **Commissioner.** "Commissioner" means the commissioner of the Department of Human Services or the commissioner's designated representative

Subp 4 **Department.** "Department" means the Department of Human Services

Subp 5 **Department health care programs.** "Department health care programs" means.

A general assistance medical care,

B medical assistance, and

C MinnesotaCare

Subp 6 **Fee–for–service.** "Fee–for–service" means a method of payment for health services under which a specific amount is paid for each type of health service provided a recipient

Subp 7 **General assistance medical care.** "General assistance medical care" has the meaning given in Minnesota Statutes, section 256D 02, subdivision 4a

Subp 8 **Geographic area.** "Geographic area" means a portion of a county, a county, or multiple counties as designated by the commissioner for purposes of providing department health care programs through a prepaid contract

Subp 9 **Health maintenance organization or HMO.** "Health maintenance organization" or "HMO" means an organization specified in Minnesota Statutes, section 62D 02, subdivision 4

Subp 10 **Health plan.** "Health plan" means a health maintenance organization or other organization that contracts with the department to provide health services to recipients under a prepaid contract

Subp 11 **Health services.** "Health services" means the goods and services eligible for payment under a department health care program

Subp 12 **Medical assistance.** "Medical assistance" means the program authorized under title XIX of the Social Security Act and Minnesota Statutes, chapter 256B

Subp 13 **MinnesotaCare.** "MinnesotaCare" means the program authorized under Minnesota Statutes, sections 256 9351 to 256 9363

Subp 14 **Other state health care programs.** "Other state health care programs" means

A health insurance plans for state employees covered under Minnesota Statutes, section 43A 18,

B the workers' compensation system established under Minnesota Statutes, section 176 135;

C the public employees insurance program authorized under Minnesota Statutes, section 43A 316,

D insurance plans provided through the Minnesota comprehensive health association under Minnesota Statutes, sections 62E 01 to 62E 16, and

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E health insurance plans offered to local statutory or home rule charter city, county, and school district employees

Subp 15 **Prepaid contract.** "Prepaid contract" means a contract between the department and a health plan under which health services are provided recipients for a capitation rate

Subp 16 **Provider.** "Provider" means a vendor other than a health maintenance organization that has signed an agreement approved by the department for the provision of health services to a recipient

Subp 17 **Recipient.** "Recipient" means a person who is determined by the state or local agency to be eligible to receive health services under a department health care program

Subp 18 **Vendor.** "Vendor" means a vendor of medical care, other than a health maintenance organization, as defined in Minnesota Statutes, section 256B 02, subdivision 7

Statutory Authority: *MS s 256B 0644*

History: *18 SR 2651*

9505.5220 CONDITIONS OF PARTICIPATION; VENDOR OTHER THAN HEALTH MAINTENANCE ORGANIZATION.

Subpart 1 **Required participation.** As a condition of participating in the other state health care programs listed in part 9505 5210, subpart 14, a vendor other than a health maintenance organization must

A participate as a provider in the department health care programs, and

B except as provided in subparts 3 and 4, accept on a continuous basis new patients who are recipients, and use the same acceptance criteria applied to new patients who are not recipients

Subp 2 **Exclusion from other state health care programs.** A vendor that fails to comply with the requirements of this part is excluded from participating in other state health care programs listed in part 9505 5210, subpart 14, except as provided in items A to C

A In geographic areas where provider participation in department health care programs is limited by department managed care contracts, a vendor that fails to comply is not excluded from participating in insurance plans offered to local government employees

B A vendor who enrolls as a provider at the request of the department for the sole purpose of ensuring continuity of care for recipients who are temporarily ineligible for the vendor's health plan is not subject to the requirements of this part unless the vendor provides health services on a fee for service basis to patients not covered by department health care programs

C An independently owned physical therapy agency or occupational therapy agency, other than a Medicare–certified rehabilitation agency is not subject to the requirements of this part if

(1) the agency is owned by at least one physical therapist or occupational therapist who is individually Medicare–certified and enrolled as a provider in the department health care programs,

(2) the agency accepts recipients on a continuous basis, and

(3) all health services provided recipients are provided by a therapist who is individually Medicare–certified

This item does not require an agency to provide services to recipients that the agency does not provide other clients

Subp. 3 **Limiting acceptance of recipients; 20 percent threshold.** A provider may limit acceptance of new patients who are recipients, only as provided in items A to D.

A. The provider, at least annually, shall determine annual active patient caseload. Annual active patient caseload means:

(1) the total number of patient encounters that result in a billing during the provider's most recent fiscal year, or

(2) if enrolled as a provider for less than a year, the total number of patient encounters that result in a billing during the period between enrollment and the end of the provider's fiscal year

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B A provider may include, in the determination, patient encounters from all service sites enrolled under the provider's number but shall count only one patient encounter per patient per day regardless of the number of service sites involved in the patient's health care A provider may count recipients receiving health services on a fee–for–service basis and under a prepaid contract

C If at least 20 percent of the provider's annual active patient case load are and continue to be recipients, the provider may refuse to accept new patients who are recipients for the remainder of the provider's fiscal year

D The provider shall notify the department in writing at least ten days before limiting acceptance of new patients who are recipients The notice must include the active patient caseload data upon which the provider relied in calculating the percentage of patients who are recipients The provider shall provide any other information required by the commissioner to verify compliance with parts 9505 5200 to 9505 5240

Subp 4 **Waiver.** A vendor may request a waiver from the participation requirements of this part in writing from the commissioner. The commissioner shall grant a waiver for up to one year and shall include the vendor on the list of participating providers in part 9505 5240 if

A the vendor is a provider who is not accepting new patients, regardless of payer source, or

B the vendor is ineligible to enroll as a provider in the department health care programs because the vendor does not provide a covered health service

Statutory Authority: *MS s 256B 0644*

History: *18 SR 2651*

9505.5230 CONDITIONS OF PARTICIPATION; HEALTH MAINTENANCE ORGANIZATION.

Subpart 1 **Participation in department health care programs.** As a condition of participating in the other state health care programs listed in part 9505 5210, subpart 14, a health maintenance organization must participate in each department health care program within its approved service area as provided in items A to C

A A health maintenance organization must submit a response to a department request for proposals to contract as a health plan if the HMO

(1) is licensed for a service area that includes all or part of the geographic area identified in the request for proposals and does not meet its participation threshold under subpart 3, or

(2) is licensed for a service area that includes all or part of the geographic area in the request for proposals and is currently under contract with the department to provide health services under a mandatory health program in the geographic area identified in the request for proposals and will not meet its participation threshold without continuing to participate in that geographic area A mandatory health program is a health program in a geographic area where recipients must receive health services from a health plan

B An HMO required to respond under item A must submit a proposal that meets the request for proposals requirements authorized in statute and rule for health plan contracts

C. Before issuing a request for proposals in a geographic area, the commissioner shall notify HMOs licensed for a service area within the geographic area whether a response is required

Subp 2. **Exclusion from other state health care programs.** A health maintenance organization that fails to comply with the requirements of this part is not eligible to contract to provide health services covered under the other state health care programs listed in part 9505 5210, subpart 14

Subp 3 **Participation threshold.** Before issuing a request for proposals for health plan contracts, the commissioner shall determine whether each health maintenance organization licensed for a service area within the geographic area has met its participation threshold

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A An HMO has met its participation threshold if it has enrolled at least its proportion of the market share of recipients, calculated as provided in this item Assuming the definitions listed below, that calculation is made as described after the definitions

(1) A means the total number of persons enrolled statewide in the specific health maintenance organization,

(2) B means the total number of persons enrolled statewide in health maintenance organizations,

(3) C means the number of recipients enrolled statewide in the specific health maintenance organization, and

(4) D means the total number of recipients statewide in health maintenance organizations plus the estimated total number of recipients to be enrolled in the geographic area specified in the department's request for a proposal

If C divided by D is a number less than the number obtained by dividing A by B,

$$\left[\frac{C}{D} \text{ is less than } \frac{A}{B}\right]$$

the health maintenance organization has not enrolled its market share of recipients

B The total number of persons enrolled statewide in health maintenance organizations is determined annually using the number in the most recent annual health maintenance organization report issued by the Minnesota Department of Health The Minnesota Department of Health report entitled "HMOS, Statistical Report on Health Maintenance Organization Operations in Minnesota" is incorporated by reference and is updated annually It is available at the Minnesota Legislative Reference Library, 600 State Office Building, 100 Constitution Avenue, Saint Paul, Minnesota 55155

C The number of recipients enrolled in health maintenance organizations is determined using the most recent monthly enrollment report maintained by the Minnesota Department of Human Services The monthly enrollment report is available from the Department of Human Services, Coordinated Care Division, 444 Lafayette Road, Saint Paul, Minnesota 55155-3854

Subp 4 **HMO subcontracts with other HMOs.**

A Except as provided in items B and C, if a health maintenance organization subcontracts all or a portion of its provider network to another HMO, only one HMO, as designated by the contracting HMOs, may count the enrolled recipients for purposes of compliance with this part.

B If at least 75 percent of all persons enrolled with a health maintenance organization are recipients and the HMO does not serve enrollees covered by Medicare or commercial insurance, another HMO with which it subcontracts may not count its enrolled recipients for purposes of compliance with this subpart

C Two or more health maintenance organizations that have entered into a written agreement to jointly contract as a single health plan with the department may request a waiver from item A to proportionately count enrolled recipients for purposes of compliance with this part The commissioner shall grant a waiver permitting each HMO to count a percentage of recipient enrollees for the term of the health plan contract if proportionate counting has the same effect on recipient access to health services as an allocation under item A

Subp 5 **Licensed health maintenance organization that is a controlling organization.** If a corporation consists of more than one health maintenance organization licensed under Minnesota Statutes, chapter 62D, each of the licensed HMOs must comply with this part; except, if one of the corporation's licensed HMOs is a controlling organization as defined under Minnesota Statutes, section 317A 011, subdivision 18, the controlling organization must comply, using the combined market share of its related health maintenance organizations to calculate the proportion of market share

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Subp. 6 **Other enrollment limitation.** If three or more health plans are under contract with the department in a geographic area, each HMO in the geographic area may limit its enrollment of recipients to 55 percent of the total number of recipients enrolled in the geographic area.

Statutory Authority: *MS s 256B 0644*

History: *18 SR 2651*

9505.5240 REPORTS; EXCLUSION FROM PARTICIPATION.

Subpart 1 **Quarterly reports to state agencies.** The commissioner shall submit quarterly reports to the commissioners of Employee Relations, Labor and Industry, and Commerce identifying the providers and health maintenance organizations in compliance with parts 9505 5200 to 9505 5230 The commissioner shall submit a master report of participating providers and HMOs on April 1 of each year and shall submit subsequent quarterly amendments. The commissioner shall publish in the State Register notice of the availability of the reports The reports must be in a format mutually agreeable to the affected agencies.

Subp 2 **Notice of noncompliance.** If the commissioner has reason to believe a participating provider or health maintenance organization is not in compliance with parts 9505 5200 to 9505 5240, the commissioner shall notify the provider or HMO in writing of the alleged noncompliance The notice must state that the commissioners listed in subpart 1 will be notified and the provider or health maintenance organization will be excluded from participating in the other state health care programs listed in part 9505 5210, subpart 14, unless evidence of compliance is provided within 30 days

Subp. 3 **Exclusion for noncompliance.** The commissioner shall consider evidence provided in response to a notice of alleged noncompliance. Within 30 days after receiving evidence provided, the commissioner shall notify the provider or health maintenance organization whether compliance has been demonstrated If no evidence was submitted within 30 days of the notice under subpart 2, or the commissioner determines the provider or HMO is not in compliance, the commissioner shall remove the provider or HMO from the list of participating providers and HMOs in the next subsequent quarterly report

Subp 4. **Reinstatement.** The commissioner shall reinstate on the list of participating providers and health maintenance organizations in the quarterly report under subpart 1 an excluded provider or HMO that demonstrates compliance with parts 9505 5200 to 9505 5240

Statutory Authority: *MS s 256B 0644*

History: *18 SR 2651*

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