CHAPTER 252

HOSPITALS AND COMMUNITY SERVICES FOR PERSONS WITH MENTAL RETARDATION

252.27 PARENTAL CONTRIBUTION FOR THE COST OF CHILDREN'S SERVICES.

Subdivision 1. **County of financial responsibility.** Whenever any child who has mental retardation or a related condition, or a physical disability or emotional disturbance is in 24-hour care outside the home including respite care, in a facility licensed by the commissioner of human services, the cost of services shall be paid by the county of financial responsibility determined pursuant to chapter 256G. If the child's parents or guardians do not reside in this state, the cost shall be paid by the responsible governmental agency in the state from which the child came, by the parents or guardians of the child if they are financially able, or, if no other payment source is available, by the commissioner of human services.

Subd. 1a. **Definitions.** A "related condition" is a condition that is found to be closely related to mental retardation, including, but not limited to, cerebral palsy, epilepsy, autism, and Prader-Willi syndrome and that meets all of the following criteria:

(a) is severe and chronic;

(b) results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation;

(c) requires treatment or services similar to those required for persons with mental retardation;

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

(e) is likely to continue indefinitely;

(f) results in substantial functional limitations in three or more of the following areas of major life activity: (1) self-care, (2) understanding and use of language, (3) learning, (4) mobility, (5) self-direction, (6) capacity for independent living; and

(g) is not attributable to mental illness as defined in section 245.462, subdivision 20, or an emotional disturbance as defined in section 245.4871, subdivision 15.

For purposes of paragraph (g), notwithstanding section 245.462, subdivision 20, or 245.4871, subdivision 15, "mental illness" does not include autism or other pervasive developmental disorders.

[For text of subd 2, see M.S.1994]

Subd. 2a. **Contribution amount.** (a) The natural or adoptive parents of a minor child, including a child determined eligible for medical assistance without consideration of parental income, must contribute monthly to the cost of services, unless the child is married or has been married, parental rights have been terminated, or the child's adoption is subsidized according to section 259.67 or through title IV-E of the Social Security Act.

(b) The parental contribution shall be the greater of a minimum monthly fee of $25 for households with adjusted gross income of $30,000 and over, or an amount to be computed by applying to the adjusted gross income of the natural or adoptive parents that exceeds 150 percent of the federal poverty guidelines for the applicable household size, the following schedule of rates:

(1) on the amount of adjusted gross income over 150 percent of poverty, but not over $50,000, ten percent;

(2) on the amount of adjusted gross income over 150 percent of poverty and over $50,000 but not over $60,000, 12 percent;

(3) on the amount of adjusted gross income over 150 percent of poverty, and over $60,000 but not over $75,000, 14 percent; and

(4) on all adjusted gross income amounts over 150 percent of poverty, and over $75,000, 15 percent.

If the child lives with the parent, the parental contribution is reduced by $200, except that the parent must pay the minimum monthly $25 fee under this paragraph. If the child resides in an institution specified in section 256B.35, the parent is responsible for the personal needs allowance specified under that section in addition to the parental contribution determined under this section. The parental contribution is reduced by any amount required to be paid directly to the child pursuant to a court order, but only if actually paid.

(c) The household size to be used in determining the amount of contribution under paragraph (b) includes natural and adoptive parents and their dependents under age 21, including the child receiving services. Adjustments in the contribution amount due to annual changes in the federal poverty guidelines shall be implemented on the first day of July following publication of the changes.

(d) For purposes of paragraph (b), "income" means the adjusted gross income of the natural or adoptive parents determined according to the previous year's federal tax form.

(e) The contribution shall be explained in writing to the parents at the time eligibility for services is being determined. The contribution shall be made on a monthly basis effective with the first month in which the child receives services. Annually upon redetermination or at termination of eligibility, if the contribution exceeded the cost of services provided, the local agency or the state shall reimburse that excess amount to the parents, either by direct reimbursement if the parent is no longer required to pay a contribution, or by a reduction in or waiver of parental fees until the excess amount is exhausted.

(f) The monthly contribution amount must be reviewed at least every 12 months; when there is a change in household size; and when there is a loss of or gain in income from one month to another in excess of ten percent. The local agency shall mail a written notice 30 days in advance of the effective date of a change in the contribution amount. A decrease in the contribution amount is effective in the month that the parent verifies a reduction in income or change in household size.

(g) Parents of a minor child who do not live with each other shall each pay the contribution required under paragraph (a), except that a court–ordered child support payment actually paid on behalf of the child receiving services shall be deducted from the contribution of the parent making the payment.

(h) The contribution under paragraph (b) shall be increased by an additional five percent if the local agency determines that insurance coverage is available but not obtained for the child. For purposes of this section, "available" means the insurance is a benefit of employment for a family member at an annual cost of no more than five percent of the family's annual income. For purposes of this section, insurance means health and accident insurance coverage, enrollment in a nonprofit health service plan, health maintenance organization, self–insured plan, or preferred provider organization.

Parents who have more than one child receiving services shall not be required to pay more than the amount for the child with the highest expenditures. There shall be no resource contribution from the parents. The parent shall not be required to pay a contribution in excess of the cost of the services provided to the child, not counting payments made to school districts for education–related services. Notice of an increase in fee payment must be given at least 30 days before the increased fee is due.

[For text of subd 2b, see M.S.1994]

Subd. 2c. [Repealed, 1995 c 207 art 6 s 124]

[For text of subds 3 and 4, see M.S.1994]

Subd. 5. **Determination; redetermination; notice.** A determination order and notice of parental fee shall be mailed to the parent at least annually, or more frequently as provided in Minnesota Rules, parts 9550.6220 to 9550.6229. The determination order and notice shall contain the following information:

(1) the amount the parent is required to contribute;

(2) notice of the right to a redetermination and appeal; and

(3) the telephone number of the division at the department of human services that is responsible for redeterminations.

Subd. 6. **Appeals.** A parent may appeal the determination or redetermination of an obligation to make a contribution under this section, according to section 256.045. The parent must make a request for a hearing in writing within 30 days of the date the determination or redetermination order is mailed, or within 90 days of such written notice if the parent shows good cause why the request was not submitted within the 30–day time limit. The commissioner must provide the parent with a written notice that acknowledges receipt of the request and notifies the parent of the date of the hearing. While the appeal is pending, the parent has the rights regarding making payment that are provided in Minnesota Rules, part 9550.6235. If the commissioner's determination or redetermination is affirmed, the parent shall, within 90 calendar days after the date an order is issued under section 256.045, subdivision 5, pay the total amount due from the effective date of the notice of determination or redetermination that was appealed by the parent. If the commissioner's order under this subdivision results in a decrease in the parental fee amount, any payments made by the parent that result in an overpayment shall be credited to the parent as provided in Minnesota Rules, part 9550.6235, subpart 3.

History: *1995 c 207 art 6 s 4–8*

252.275 SEMI–INDEPENDENT LIVING SERVICES FOR PERSONS WITH MENTAL RETARDATION OR RELATED CONDITIONS.

[For text of subds 1 and 1a, see M.S.1994]

Subd. 3. **Reimbursement.** Counties shall be reimbursed for all expenditures made pursuant to subdivision 1 at a rate of 70 percent, up to the allocation determined pursuant to subdivisions 4 and 4b. However, the commissioner shall not reimburse costs of services for any person if the costs exceed the state share of the average medical assistance costs for services provided by intermediate care facilities for a person with mental retardation or a related condition for the same fiscal year, and shall not reimburse costs of a one–time living allowance for any person if the costs exceed $1,500 in a state fiscal year. The commissioner may make payments to each county in quarterly installments. The commissioner may certify an advance of up to 25 percent of the allocation. Subsequent payments shall be made on a reimbursement basis for reported expenditures and may be adjusted for anticipated spending patterns.

Subd. 4. **Formula.** The commissioner shall allocate funds on a calendar year basis. Beginning with the calendar year in the 1996 grant period, funds shall be allocated first in amounts equal to each county's guaranteed floor according to subdivision 4b, with any remaining available funds allocated based on each county's portion of the statewide expenditures eligible for reimbursement under this section during the 12 months ending on June 30 of the preceding calendar year.

If the legislature appropriates funds for special purposes, the commissioner may allocate the funds based on proposals submitted by the counties to the commissioner in a format prescribed by the commissioner. Nothing in this section prevents a county from using other funds to pay for additional costs of semi–independent living services.

Subd. 4a. [Repealed, 1995 c 207 art 3 s 23]

[For text of subds 4b to 7, see M.S.1994]

Subd. 8. **Use of federal funds and transfer of funds to medical assistance.** (a) The commissioner shall make every reasonable effort to maximize the use of federal funds for semi–independent living services.

(b) The commissioner shall reduce the payments to be made under this section to each county from January 1, 1994 to June 30, 1996, by the amount of the state share of medical assistance reimbursement for services other than residential services provided under the home and community–based waiver program under section 256B.092 from January 1, 1994

to June 30, 1996, for clients for whom the county is financially responsible and who have been transferred by the county from the semi–independent living services program to the home and community–based waiver program. Unless otherwise specified, all reduced amounts shall be transferred to the medical assistance state account.

(c) For fiscal year 1997, the base appropriation available under this section shall be reduced by the amount of the state share of medical assistance reimbursement for services other than residential services provided under the home and community–based waiver program authorized in section 256B.092 from January 1, 1995 to December 31, 1995, for persons who have been transferred from the semi–independent living services program to the home and community–based waiver program. The base appropriation for the medical assistance state account shall be increased by the same amount.

(d) For purposes of calculating the guaranteed floor under subdivision 4b and to establish the calendar year 1996 allocations, each county's original allocation for calendar year 1995 shall be reduced by the amount transferred to the state medical assistance account under paragraph (b) during the six months ending on June 30, 1995. For purposes of calculating the guaranteed floor under subdivision 4b and to establish the calendar year 1997 allocations, each county's original allocation for calendar year 1996 shall be reduced by the amount transferred to the state medical assistance account under paragraph (b) during the six months ending on December 31, 1995.

[For text of subd 9, see M.S.1994]

Subd. 10. [Repealed, 1995 c 207 art 3 s 23]

History: *1995 c 207 art 3 s 2–4*

252.292 COMMUNITY SERVICES CONVERSION PROJECT.

[For text of subds 1 to 3, see M.S.1994]

Subd. 4. **Facility rates.** For purposes of this section, the commissioner shall establish payment rates under section 256B.501 and Minnesota Rules, parts 9553.0010 to 9553.0080, except that, in order to facilitate an orderly transition of residents from community intermediate care facilities for persons with mental retardation or related conditions to services provided under the home and community–based services program, the commissioner may, in a contract with the provider, modify the effect of provisions in Minnesota Rules, parts 9553.0010 to 9553.0080, as stated in clauses (a) to (i):

(a) extend the interim and settle–up rate provisions to include facilities covered by this section;

(b) extend the length of the interim period but not to exceed 12 months. The commissioner may grant a variance to exceed the 12–month interim period, as necessary, for facilities which are licensed and certified to serve more than 99 persons. In no case shall the commissioner approve an interim period which exceeds 24 months;

(c) waive the investment per bed limitations for the interim period and the settle–up rate;

(d) limit the amount of reimbursable expenses related to the acquisition of new capital assets;

(e) prohibit the acquisition of additional capital debt or refinancing of existing capital debt unless prior approval is obtained from the commissioner;

(f) establish an administrative operating cost limitation for the interim period and the settle–up rate;

(g) require the retention of financial and statistical records until the commissioner has audited the interim period and the settle–up rate;

(h) require that the interim period be audited by a certified or licensed public accounting firm; or

(i) change any other provision to which all parties to the contract agree.

History: *1995 c 207 art 3 s 5*

252.431 SUPPORTED EMPLOYMENT SERVICES; DEPARTMENTAL DUTIES; COORDINATION.

The commissioners of economic security, human services, and children, families, and learning shall ensure that supported employment services provided as part of a comprehensive service system will:

(1) provide the necessary supports to assist persons with severe disabilities to obtain and maintain employment in normalized work settings available to the general work force that:

(i) maximize community and social integration; and

(ii) provide job opportunities that meet the individual's career potential and interests;

(2) allow persons with severe disabilities to actively participate in the planning and delivery of community–based employment services at the individual, local, and state level; and

(3) be coordinated among the departments of human services, economic security, and children, families, and learning to:

(i) promote the most efficient and effective funding;

(ii) avoid duplication of services; and

(iii) improve access and transition to employability services.

The commissioners of economic security, human services, and education shall report to the legislature by January 1993 on the steps taken to implement this section.

History: *1Sp1995 c 3 art 16 s 13*

252.46 PAYMENT RATES.

Subdivision 1. **Rates.** (a) Payment rates to vendors, except regional centers, for county–funded day training and habilitation services and transportation provided to persons receiving day training and habilitation services established by a county board are governed by subdivisions 2 to 19. The commissioner shall approve the following three payment rates for services provided by a vendor:

(1) a full–day service rate for persons who receive at least six service hours a day, including the time it takes to transport the person to and from the service site;

(2) a partial–day service rate that must not exceed 75 percent of the full–day service rate for persons who receive less than a full day of service; and

(3) a transportation rate for providing, or arranging and paying for, transportation of a person to and from the person's residence to the service site.

(b) The commissioner may also approve an hourly job–coach, follow–along rate for services provided by one employee at or en route to or from community locations to supervise, support, and assist one person receiving the vendor's services to learn job–related skills necessary to obtain or retain employment when and where no other persons receiving services are present and when all the following criteria are met:

(1) the vendor requests and the county recommends the optional rate;

(2) the service is prior authorized by the county on the Medicaid Management Information System for no more than 414 hours in a 12–month period and the daily per person charge to medical assistance does not exceed the vendor's approved full day plus transportation rates;

(3) separate full day, partial day, and transportation rates are not billed for the same person on the same day;

(4) the approved hourly rate does not exceed the sum of the vendor's current average hourly direct service wage, including fringe benefits and taxes, plus a component equal to the vendor's average hourly nondirect service wage expenses; and

(5) the actual revenue received for provision of hourly job–coach, follow–along services is subtracted from the vendor's total expenses for the same time period and those adjusted expenses are used for determining recommended full day and transportation payment rates under subdivision 5 in accordance with the limitations in subdivision 3.

(c) Medical assistance rates for home and community–based service provided under section 256B.501, subdivision 4, by licensed vendors of day training and habilitation services must not be greater than the rates for the same services established by counties under

sections 252.40 to 252.47. For very dependent persons with special needs the commissioner may approve an exception to the approved payment rate under section 256B.501, subdivision 4 or 8.

[For text of subd 2, see M.S.1994]

Subd. 3. **Rate maximum.** Unless a variance is granted under subdivision 6, the maximum payment rates for each vendor for a calendar year must be equal to the payment rates approved by the commissioner for that vendor in effect December 1 of the previous calendar year. The commissioner of finance shall include as a budget change request in each biennial detailed expenditure budget submitted to the legislature under section 16A.11 annual inflation adjustments in reimbursement rates for each vendor, based upon the projected percentage change in the urban consumer price index, all items, published by the United States Department of Labor, for the upcoming calendar year over the current calendar year.

[For text of subds 4 and 5, see M.S.1994]

Subd. 6. **Variances.** (a) A variance from the minimum or maximum payment rates in subdivisions 2 and 3 may be granted by the commissioner when the vendor requests and the county board submits to the commissioner a written variance request on forms supplied by the commissioner with the recommended payment rates. A variance to the rate maximum may be utilized for costs associated with compliance with state administrative rules, compliance with court orders, capital costs required for continued licensure, increased insurance costs, start–up and conversion costs for supported employment, direct service staff salaries and benefits, transportation, and other program related costs when any of the criteria in clauses (1) to (4) is also met:

(1) change is necessary to comply with licensing citations;

(2) a licensed vendor currently serving fewer than 70 persons with payment rates of 80 percent or less of the statewide average rates and with clients meeting the behavioral or medical criteria under clause (3) approved by the commissioner as a significant program change under section 252.28;

(3) a significant change is approved by the commissioner under section 252.28 that is necessary to provide authorized services to a new client or clients with very severe self–injurious or assaultive behavior, or medical conditions requiring delivery of physician–prescribed medical interventions requiring one–to–one staffing for at least 15 minutes each time they are performed, or to a new client or clients directly discharged to the vendor's program from a regional treatment center; or

(4) there is a need to maintain required staffing levels in order to provide authorized services approved by the commissioner under section 252.28, that is necessitated by a significant and permanent decrease in licensed capacity or clientele.

The county shall review the adequacy of services provided by vendors whose payment rates are 80 percent or more of the statewide average rates and 50 percent or more of the vendor's clients meet the behavioral or medical criteria in clause (3).

A variance under this paragraph may be approved only if the costs to the medical assistance program do not exceed the medical assistance costs for all clients served by the alternatives and all clients remaining in the existing services.

(b) A variance to the rate minimum may be granted when (1) the county board contracts for increased services from a vendor and for some or all individuals receiving services from the vendor lower per unit fixed costs result or (2) when the actual costs of delivering authorized service over a 12–month contract period have decreased.

(c) The written variance request under this subdivision must include documentation that all the following criteria have been met:

(1) The commissioner and the county board have both conducted a review and have identified a need for a change in the payment rates and recommended an effective date for the change in the rate.

(2) The vendor documents efforts to reallocate current staff and any additional staffing needs cannot be met by using temporary special needs rate exceptions under Minnesota Rules, parts 9510.1020 to 9510.1140.

(3) The vendor documents that financial resources have been reallocated before applying for a variance. No variance may be granted for equipment, supplies, or other capital expenditures when depreciation expense for repair and replacement of such items is part of the current rate.

(4) For variances related to loss of clientele, the vendor documents the other program and administrative expenses, if any, that have been reduced.

(5) The county board submits verification of the conditions for which the variance is requested, a description of the nature and cost of the proposed changes, and how the county will monitor the use of money by the vendor to make necessary changes in services.

(6) The county board's recommended payment rates do not exceed 95 percent of the greater of 125 percent of the current statewide median or 125 percent of the regional average payment rates, whichever is higher, for each of the regional commission districts under sections 462.381 to 462.396 in which the vendor is located except for the following: when a variance is recommended to allow authorized service delivery to new clients with severe self–injurious or assaultive behaviors or with medical conditions requiring delivery of physician prescribed medical interventions, or to persons being directly discharged from a regional treatment center to the vendor's program, those persons must be assigned a payment rate of 200 percent of the current statewide average rates. All other clients receiving services from the vendor must be assigned a payment rate equal to the vendor's current rate unless the vendor's current rate exceeds 95 percent of 125 percent of the statewide median or 125 percent of the regional average payment rates, whichever is higher. When the vendor's rates exceed 95 percent of 125 percent of the statewide median or 125 percent of the regional average rates, the maximum rates assigned to all other clients must be equal to the greater of 95 percent of 125 percent of the statewide median or 125 percent of the regional average rates. The maximum payment rate that may be recommended for the vendor under these conditions is determined by multiplying the number of clients at each limit by the rate corresponding to that limit and then dividing the sum by the total number of clients.

(d) The commissioner shall have 60 calendar days from the date of the receipt of the complete request to accept or reject it, or the request shall be deemed to have been granted. If the commissioner rejects the request, the commissioner shall state in writing the specific objections to the request and the reasons for its rejection.

[For text of subds 7 to 16, see M.S.1994]

Subd. 17. **Hourly rate structure.** Counties participating as host counties under the pilot study of hourly rates established under Laws 1988, chapter 689, article 2, section 117, may recommend continuation of the hourly rates for participating vendors. The recommendation must be made annually under subdivision 5 and according to the methods and standards provided by the commissioner. The commissioner shall approve the hourly rates when service authorization, billing, and payment for services is possible through the Medicaid management information system and the other criteria in this subdivision are met. Counties and vendors operating under the pilot study of hourly rates established under Laws 1988, chapter 689, article 2, section 117, shall work with the commissioner to translate the hourly rates and actual expenditures into rates meeting the criteria in subdivisions 1 to 16 unless hourly rates are approved under this subdivision. If the rates meeting the criteria in subdivisions 1 to 16 are lower than the county's or vendor's current rate, the county or vendor must continue to receive the current rate.

[For text of subd 18, see M.S.1994]

Subd. 19. **Vendor appeals.** With the concurrence of the county board, a vendor may appeal the commissioner's rejection of a variance request which has been submitted by the county under subdivision 6 and may appeal the commissioner's denial under subdivision 9 of a rate which has been recommended by the county. To appeal, the vendor and county board must file a written notice of appeal with the commissioner. The notice of appeal must be filed or received by the commissioner within 45 days of the postmark date on the commissioner's notification to the vendor and county agency that a variance request or county recommended rate has been denied. The notice of appeal must specify the reasons for the appeal, the dollar amount in dispute, and the basis in statute or rule for challenging the commissioner's decision.

Within 45 days of receipt of the notice of appeal, the commissioner must convene a reconciliation conference to attempt to resolve the rate dispute. If the dispute is not resolved to the satisfaction of the parties, the parties may initiate a contested case proceeding under sections 14.57 to 14.69. In a contested case hearing held under this section, the appealing party must demonstrate by a preponderance of the evidence that the commissioner incorrectly applied the governing law or regulations, or that the commissioner improperly exercised the commissioner's discretion, in refusing to grant a variance or in refusing to adopt a county recommended rate.

Until the appeal is fully resolved, payments must continue at the existing rate pending the appeal. Retroactive payments consistent with the final decision shall be made after the appeal is fully resolved.

Subd. 20. **Study of day training and habilitation vendors.** The commissioner shall study the feasibility of grouping vendors of similar size, location, direct service staffing needs or performance outcomes to establish payment rate limits that define cost–effective service. Based on the conclusions of the feasibility study the department shall consider developing a method to redistribute dollars from less cost–effective to more cost–effective services based on vendor achievement of performance outcomes. The department shall report to the legislature by January 15, 1996, with results of the study and recommendations for further action. The department shall consult with an advisory committee representing counties, service consumers, vendors, and the legislature.

History: *1995 c 207 art 3 s 6–11*

252.47 [Repealed, 1995 c 207 art 7 s 43]