CHAPTER 256B

MEDICAL ASSISTANCE FOR NEEDY PERSONS

256B.035 MANAGED CARE.

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

History: *1995 c 234 art 8 s 56*

256B.037 PROSPECTIVE PAYMENT OF DENTAL SERVICES.

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

The commissioner may exclude from participation in the demonstration project any or all groups currently excluded from participation in the prepaid medical assistance program under section 256B.69. Except for persons excluded from participation in the demonstration project, all persons who have been determined eligible for medical assistance, general assistance medical care and, if applicable, MinnesotaCare and reside in the designated geographic areas are required to enroll in a dental plan to receive their dental care services. Except for

emergency services or out–of–plan services authorized by the dental plan, recipients must receive their dental services from dental care providers who are part of the dental plan provider network.

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

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

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

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

(2) randomly 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.

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

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.

[For text of subd 5, see M.S.1994]

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 copayments 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 an integrated service network 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: *1995 c 234 art 6 s 22–33*

256B.04 DUTIES OF STATE AGENCY.

[For text of subds 1 to 11, see M.S.1994]

Subd. 12. 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:

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

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

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

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.

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.

[For text of subds 13 to 17, see M.S.1994]

Subd. 18. **Applications for medical assistance.** The state agency may take applications for medical assistance and conduct eligibility determinations for MinnesotaCare enrollees who are required to apply for medical assistance according to section 256.9353, subdivision 3, paragraph (b).

History: *1995 c 233 art 2 s 56; 1995 c 234 art 6 s 34*

256B.042 THIRD PARTY LIABILITY.

[For text of subd 1, see M.S.1994]

Subd. 2. **Lien enforcement.** 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. 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. For purposes of this section, "state agency" includes authorized agents of the state agency.

[For text of subds 3 to 5, see M.S.1994]

History: *1995 c 207 art 6 s 26*

256B.055 ELIGIBILITY CATEGORIES.

[For text of subds 1 to 10, see M.S.1994]

Subd. 10a. **Children.** This subdivision supersedes subdivision 10, as long as the Minnesota health care reform waiver remains in effect. When the waiver expires, this subdivision expires and the commissioner of human services shall publish a notice in the State Register and notify the revisor of statutes. Medical assistance may be paid for a child less than two years of age, whose mother was eligible for and receiving medical assistance at the time of birth and who remains in the mother's household or who is in a family with countable income that is equal to or less than the income standard established under section 256B.057, subdivision 1.

[For text of subd 11, see M.S.1994]

Subd. 12. **Disabled children.** (a) A person is eligible for medical assistance if the person is under age 19 and qualifies as a disabled individual under United States Code, title 42, section 1382c(a), and would be eligible for medical assistance under the state plan if residing in a medical institution, and the child requires a level of care provided in a hospital, nursing facility, or intermediate care facility for persons with mental retardation or related conditions, 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. Eligibility under this section must be determined annually.

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

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

(c) For purposes of this subdivision, "nursing facility" means a facility which provides nursing care as defined in section 144A.01, subdivision 5, licensed pursuant to sections 144A.02 to 144A.10, which is appropriate if a person is in active restorative treatment; is in need of special treatments provided or supervised by a licensed nurse; or has unpredictable episodes of active disease processes requiring immediate judgment by a licensed nurse. For purposes of this subdivision, a child requires the level of care provided in a nursing facility if the child is determined by the commissioner to meet the requirements of the preadmission screening assessment document under section 256B.0911 and the home care independent rating document under section 256B.0627, subdivision 5, paragraph (f), item (iii), adjusted to address age–appropriate standards for children age 18 and under, pursuant to section 256B.0627, subdivision 5, paragraph (d), clause (2).

(d) For purposes of this subdivision, "intermediate care facility for persons with mental retardation or related conditions" or "ICF/MR" means a program licensed to provide services to persons with mental retardation 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 mental retardation or persons with related conditions 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/MR if the commissioner finds that the child has mental retardation or a related condition in accordance with section 256B.092, is in need of a 24–hour plan of care and active treatment similar to persons with mental retardation, and there is a reasonable indication that the child will need ICF/MR services.

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

(f) If a child meets the conditions in paragraph (b), (c), or (d), 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/MR, 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 ICFs/MR;

(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), 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.

(g) Children eligible for medical assistance services under section 256B.055, subdivision 12, as of June 30, 1995, must be screened according to the criteria in this subdivision prior to January 1, 1996. Children found to be ineligible may not be removed from the program until January 1, 1996.

History: *1995 c 207 art 6 s 27; 1995 c 234 art 6 s 35*

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

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

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

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

Subd. 4. **Income.** To be eligible for medical assistance, a person must not have, or anticipate receiving, semiannual income in excess of 120 percent of the income standards by family size used in the aid to families with dependent children program, except that families and children may have an income up to 133–1/3 percent of the AFDC income standard. In computing income to determine eligibility of persons who are not residents of long–term care facilities, the commissioner shall disregard increases in income as required by Public Law Numbers 94–566, section 503; 99–272; and 99–509. Veterans aid and attendance benefits are considered income to the recipient.

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

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

[For text of subd 5, see M.S.1994]

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

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

[For text of subds 6 to 8, see M.S.1994]

History: *1995 c 207 art 6 s 28,29; 1995 c 248 art 17 s 1–4*

NOTE: The amendment to subdivision 3b by Laws 1995, chapter 207, article 6, section 28, is effective retroactive to August 11, 1993. See Laws 1995, chapter 207, article 6, section 125, subdivision 3.

NOTE: Subdivision 5a, as added by Laws 1995, chapter 248, article 17, section 3, ceases to be effective if a federal agency determines that implementation of subdivision 5a would cause a loss of federal funding. See Laws 1995, chapter 248, article 17, section 8.

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

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

Subd. 1b. **Pregnant women and infants; expansion.** This subdivision supersedes subdivision 1 as long as the Minnesota health care reform waiver remains in effect. When the waiver expires, the commissioner of human services shall publish a notice in the State Register and notify the revisor of statutes. An infant less than two years of age or a pregnant woman who has written verification of a positive pregnancy test from a physician or licensed registered nurse, is eligible for medical assistance if countable family income is equal to or less than 275 percent of the federal poverty guideline for the same family size. For purposes of this subdivision, "countable family income" means the amount of income considered available using the methodology of the AFDC program, except for the earned income disregard and employment deductions. An amount equal to the amount of earned income exceeding 275 percent of the federal poverty guideline, up to a maximum of the amount by which the combined total of 185 percent of the federal poverty guideline plus the earned income disregards and deductions of the AFDC program exceeds 275 percent of the federal poverty guideline will be deducted for pregnant women and infants less than two years of age. Eligibility for a pregnant woman or infant less than two years of age under this subdivision must be determined without regard to asset standards established in section 256B.056, subdivision 3.

An infant born on or after January 1, 1991, 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 second birthday, as long as the child remains in the woman's household.

[For text of subds 2 and 2a, see M.S.1994]

Subd. 2b. **No asset test for children and their parents; expansion.** This subdivision supersedes subdivision 2a as long as the Minnesota health care reform waiver remains in effect. When the waiver expires, this subdivision expires and the commissioner of human services shall publish a notice in the State Register and notify the revisor of statutes. Eligibility for medical assistance for a person under age 21, and the person's parents or relative caretakers as defined in the aid to families with dependent children program according to chapter 256, who are eligible under section 256B.055, subdivision 3, and who live in the same household as the person eligible under age 21, must be determined without regard to asset standards established in section 256B.056.

[For text of subds 3 to 6, see M.S.1994]

History: *1995 c 234 art 6 s 36,37*

256B.0575 AVAILABILITY OF INCOME FOR INSTITUTIONALIZED PERSONS.

When an institutionalized person is determined eligible for medical assistance, the income that exceeds the deductions in paragraphs (a) and (b) must be applied to the cost of institutional care.

(a) The following amounts must be deducted from the institutionalized person's income in the following order:

(1) the personal needs allowance under section 256B.35 or, for a veteran who does not have a spouse or child, or a surviving spouse of a veteran having no child, the amount of an improved pension received from the veteran's administration not exceeding $90 per month;

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

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

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

(5) a monthly allowance for children under age 18 which, together with the net income of the children, would provide income equal to the medical assistance standard for families and children according to section 256B.056, subdivision 4, for a family size that includes only the minor children. This deduction applies only if the children do not live with the community spouse;

(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; and

(8) amounts for reasonable expenses incurred for necessary medical or remedial care for the institutionalized spouse that are not medical assistance covered expenses and that are not subject to payment by a third party.

For purposes of clause (6), "other family member" means a person who resides with the community spouse and who is a minor or dependent child, dependent parent, or dependent sibling of either spouse. "Dependent" means a person who could be claimed as a dependent for federal income tax purposes under the Internal Revenue Code.

(b) Income shall be allocated to an institutionalized person for a period of up to three calendar months, in an amount equal to the medical assistance standard for a family size of one if:

(1) a physician certifies that the person is expected to reside in the long–term care facility for three calendar months or less;

(2) if the person has expenses of maintaining a residence in the community; and

(3) if one of the following circumstances apply:

(i) the person was not living together with a spouse or a family member as defined in paragraph (a) when the person entered a long–term care facility; or

(ii) the person and the person's spouse become institutionalized on the same date, in which case the allocation shall be applied to the income of one of the spouses.

For purposes of this paragraph, a person is determined to be residing in a licensed nursing home, regional treatment center, or medical institution if the person is expected to remain for a period of one full calendar month or more.

History: *1995 c 207 art 6 s 30*

NOTE: The amendment to paragraph (a), clause (5), by Laws 1995, chapter 207, article 6, section 30, is effective retroactive to January 1, 1994. See Laws 1995, chapter 207, article 6, section 125, subdivision 5.

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

Subdivision 1. **Definitions.** (a) For purposes of this section, the terms defined in this subdivision have the meanings given them.

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

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

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

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

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

(1) in a hospital, nursing facility, or intermediate care facility for persons with mental retardation, or receiving home and community–based services under section 256B.0915 or 256B.49, 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 mental retardation, and is not receiving home and community–based services under section 256B.0915 or 256B.49.

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

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

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

(i) $14,148;

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

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

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

(i) $20,000;

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

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

If the assets available to the community spouse are already at the limit permissible under this section, or the higher limit attributable to increases under subdivision 4, no assets

may be transferred from the institutionalized spouse to the community spouse. The transfer must be made as soon as practicable after the date the institutionalized spouse is determined eligible for medical assistance, or within the amount of time needed for any court order required for the transfer. On January 1, 1994, and every January 1 thereafter, the limits in this subdivision shall be adjusted by the same percentage change in the consumer price index for all urban consumers (all items; United States city average) between the two previous Septembers. These adjustments shall also be applied to the limits in subdivision 5.

[For text of subd 4, see M.S.1994]

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

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

(i) $14,148;

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

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

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

(i) $20,000;

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

(iii) the amount required by court order to be paid to the community spouse. 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, during the continuous period of institutionalization, no assets of the community spouse are considered available to the institutionalized spouse, unless the institutionalized spouse has been found eligible under paragraph (b).

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

(e) For purposes of this section, assets do not include assets excluded under the supplemental security income program.

History: *1995 c 207 art 6 s 31–33*

256B.0595 PROHIBITIONS ON TRANSFER; EXCEPTIONS.

Subdivision 1. **Prohibited transfers.** (a) For transfers of assets made on or before August 10, 1993, if a person or the person's spouse has given away, sold, or disposed 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 program, within 30 months before or any time after the date of institutionalization if the person has been determined eligible for medical assistance, or within 30 months before or any time after the date of the first approved application for medical assistance if the person has not yet been determined eligible for medical assistance, the person is ineligible for long–term care services for the period of time determined under subdivision 2.

(b) Effective for transfers made after August 10, 1993, a person, a 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 person or 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. 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 applies for medical assistance, or 36 months before or any time after a medical assistance recipient becomes institutionalized, 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 person is ineligible for long–term care services for the period of time determined under subdivision 2, unless the 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. Notwithstanding the provisions of this paragraph, in the case of payments from a trust or portions of a trust that are considered transfers of assets under federal law, any transfers made within 60 months before or any time after an institutionalized person applies for medical assistance and within 60 months before or any time after a medical assistance recipient becomes institutionalized, 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 person or the person's spouse is entitled but does not receive due to action by the person, the 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 person or the 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 which was in existence when the service was performed, the care or services directly benefited the person, and the payments made represented reasonable compensation for the care or services provided. A notarized written agreement is not required if payment for the services was made within 60 days after the service was provided.

(e) This section applies to the portion of any asset or interest that a person, a 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 person or the person's spouse, to any trust, annuity, or other instrument, that exceeds the value of the benefit likely to be returned to the person or spouse while alive, based on estimated life expectancy using the life expectancy tables employed by the supplemental security income program to determine the value of an agreement for services for life. The commissioner may adopt rules reducing life expectancies based on the need for long–term care.

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

(g) Effective for transfers made on or after July 1, 1995, or upon federal approval, whichever is later, a person, a 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 person or person's spouse, may not give away, sell, or dispose of, for less than fair market value, any asset or interest therein, for the purpose of establishing or maintaining medical assistance eligibility. For purposes of determining eligibility for long–term care services, any transfer of such assets within 60 months before, or any time after, an institutionalized person applies for medical assistance, or 60 months before, or any time after, a medical assistance recipient becomes institutionalized, 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 person is ineligible for long–term care services for the period of time determined under subdivision 2, unless the 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.

Subd. 2. **Period of ineligibility.** (a) For any uncompensated transfer occurring on or before August 10, 1993, the number of months of ineligibility for long–term care services shall be the lesser of 30 months, or the uncompensated transfer amount 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 month in which the assets were transferred. If the transfer was not reported to the local agency at the time of application, and the applicant received long–term care 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 the cost of long–term care services provided during the period of ineligibility, or for the uncompensated amount of the transfer, whichever is less. The action may be brought by the state or the local agency responsible for providing medical assistance under chapter 256G. 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.

(b) 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 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 in the month the first uncompensated transfer was made. If the transfer was not reported to the local agency at the time of application, and the applicant 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 the cost of medical assistance services provided during the period of ineligibility, or for the uncompensated amount of the transfer, whichever is less. The action may be brought by the state or the local agency responsible for providing medical assistance under chapter 256G. 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.

(c) If a calculation of a penalty period results in a partial month, payments for long–term care services shall be reduced in an amount equal to the fraction, except that in calculating the value of uncompensated transfers, if the total value of all uncompensated transfers made in a month does not exceed $1,000, then such transfers shall be disregarded for each month prior to the month of application for or during receipt of medical assistance.

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 of the individual's admission to the facility, and who pro-

vided care to the individual that permitted the individual to reside at home rather than 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 the excess resources created by the uncompensated transfer because denial of eligibility would cause undue hardship for the individual, based on imminent threat to the individual's health and well–being.

(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 granted 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; or

(3) 36 months if transferred in any other manner after August 10, 1993,

or the amount of the uncompensated transfer, whichever is less, together with the costs incurred due to the action. The action may be brought by the state or the local agency responsible for providing medical assistance under chapter 256G.

Subd. 4. **Other exceptions to transfer prohibition.** An institutionalized person 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 excess assets. 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 granted within:

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

(ii) 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; or

(iii) 36 months of a transfer if transferred in any other manner after August 10, 1993,

or the amount of the uncompensated transfer, whichever is less, together with the costs incurred due to the action. The action may be brought by the state or the local agency responsible for providing medical assistance under this chapter; or

(6) for transfers occurring after August 10, 1993, the assets were transferred by the person or person's spouse: (i) into a trust established solely for the 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 solely for the benefit of an individual who is under 65 years of age who is disabled as defined by the Supplemental Security Income program.

[For text of subds 5 and 6, see M.S.1994]

History: *1995 c 207 art 6 s 34–37*

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

256B.06 ELIGIBILITY; MIGRANT WORKERS; CITIZENSHIP.

[For text of subd 3, see M.S.1994]

Subd. 4. **Citizenship requirements.** Eligibility for medical assistance is limited to citizens of the United States and aliens lawfully admitted for permanent residence or otherwise permanently residing in the United States under the color of law. Aliens who are seeking legalization under the Immigration Reform and Control Act of 1986, Public Law Number 99–603, who are under age 18, over age 65, blind, disabled, or Cuban or Haitian, and who meet the eligibility requirements of medical assistance under subdivision 1 and sections 256B.055 to 256B.062 are eligible to receive medical assistance. Pregnant women who are aliens seeking legalization under the Immigration Reform and Control Act of 1986, Public Law Number 99–603, and who meet the eligibility requirements of medical assistance under subdivision 1 are eligible for payment of care and services through the period of pregnancy and six weeks postpartum. Payment shall also be made for care and services that are furnished to an alien, regardless of immigration status, who otherwise meets the eligibility requirements of this section if such care and services are necessary for the treatment of an emergency medical condition, except for organ transplants and related care and services. For purposes of this subdivision, the term "emergency medical condition" means a medical condition, including labor and delivery, that if not immediately treated could cause a person physical or mental disability, continuation of severe pain, or death.

History: *1995 c 207 art 6 s 38*

256B.0625 COVERED SERVICES.

[For text of subds 1 to 4a, see M.S.1994]

Subd. 5. **Community mental health center services.** Medical assistance covers community mental health center services provided by a community mental health center that meets the requirements in paragraphs (a) to (j).

(a) The provider is licensed under Minnesota Rules, parts 9520.0750 to 9520.0870.

(b) The provider provides mental health services under the clinical supervision of a mental health professional who is licensed for independent practice at the doctoral level or by a board–certified psychiatrist or a psychiatrist who is eligible for board certification. Clinical supervision has the meaning given in Minnesota Rules, part 9505.0323, subpart 1, item F.

(c) The provider must be a private nonprofit corporation or a governmental agency and have a community board of directors as specified by section 245.66.

(d) The provider must have a sliding fee scale that meets the requirements in Minnesota Rules, part 9550.0060, 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, multiple family group psychotherapy, psychological testing, and medication management. In addition, the provider must provide or be capable of providing upon request of the local mental health authority day treatment services and professional home–based mental health services. The provider must have the capacity to provide such services to specialized populations such as the elderly, families with children, persons who are seriously and persistently mentally ill, and children who are seriously emotionally disturbed.

(f) The provider must be capable of providing the services specified in paragraph (e) to individuals who are diagnosed with both mental illness or emotional disturbance, and chemical dependency, and to individuals dually diagnosed with a mental illness or emotional disturbance and mental retardation or a related condition.

(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.

[For text of subds 6a and 7, see M.S.1994]

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

Subd. 8a. **Occupational therapy.** Medical assistance covers occupational therapy and related services. 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.

[For text of subds 9 to 12, see M.S.1994]

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

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

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

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

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

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

(ii) over–the–counter drugs, except for antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, and vitamins for children under the age of seven and pregnant or nursing women;

(iii) any other over–the–counter drug identified by the commissioner, in consultation with the drug formulary committee, as necessary, appropriate, and cost–effective for the treatment of certain specified chronic diseases, conditions or disorders, and this determination shall not be subject to the requirements of chapter 14;

(iv) anorectics; and

(v) drugs for which medical value has not been established.

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

(c) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs plus a fixed dispensing fee; the maximum allowable cost set by the federal government or by the commissioner plus the fixed dispensing fee; or the usual and customary price charged to the public. The pharmacy dispensing fee shall be $3.85. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. The actual acquisition cost of a drug shall be estimated by the commissioner, at average wholesale price minus nine percent. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, the maximum amount paid by other third–party payors in this state who have maximum allowable cost programs. Establishment of the amount of payment for drugs shall not be subject to the requirements of the administrative procedure act. An additional dispensing fee of $.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long–term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30–day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider will be required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse. Over–the–counter medications must be dispensed in the manufacturer's unopened package. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30–day supply. Whenever a generically equivalent product is available, payment shall be on the basis of the actual acquisition cost of the generic drug, unless the prescriber specifically indicates "dispense as written – brand necessary" on the prescription as required by section 151.21, subdivision 2.

Subd. 13a. **Drug utilization review board.** A nine–member drug utilization review board is established. The board is 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 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. The board shall be staffed by an employee of the department who shall serve as an ex officio nonvoting member of the board. The members of the board shall be appointed by the commissioner and shall serve three–year terms. The members shall be selected from lists submitted by professional associations. The commissioner shall appoint the initial members of the board for terms expiring as follows: three members for terms expiring June 30, 1996; three members for terms expiring June 30, 1997; and three members for terms expiring June 30, 1998. Members may be reappointed once. The board shall annually elect a chair from among the members.

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(g)(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.

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.

The board shall report to the commissioner annually on the date the Drug Utilization Review Annual Report is due to the Health Care Financing Administration. This report is to 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 $50 per meeting shall be paid to each board member in attendance.

Subd. 13b. **Pharmacy copayment requirements.** A copayment of $1 per prescription shall be required under the medical assistance and general assistance medical care programs according to paragraphs (a) to (d):

(a) A copayment shall not be required of children, pregnant women through the postpartum period, recipients whose only available income is a personal needs allowance in the amount established under section 256B.35 or 256B.36, recipients residing in a setting which receives funding under sections 256I.01 to 256I.06, or institutionalized recipients or, under medical assistance only, from any other persons required to be exempted under federal law;

(b) A copayment shall not be required for family planning services or supplies, psychotropic drugs or emergency services;

(c) A provider may not deny a prescription to a recipient because the recipient is unable to pay the copayment;

(d) A lower copayment shall be collected, under medical assistance only, up to the maximum permitted by federal law, for prescriptions on which federal law prohibits a $1 copayment;

(e) The amount of the copayment under this subdivision shall be subtracted from the payment under subdivision 13; and

(f) This subdivision does not apply to services under the MinnesotaCare program.

[For text of subds 14 to 16, see M.S.1994]

Subd. 17. **Transportation costs.** (a) Medical assistance covers transportation costs incurred solely for obtaining emergency medical care or transportation costs incurred by nonambulatory persons in obtaining emergency or nonemergency medical care when paid directly to an ambulance company, common carrier, or other recognized providers of trans-

portation services. For the purpose of this subdivision, a person who is incapable of transport by taxicab or bus shall be considered to be nonambulatory.

(b) Medical assistance covers special transportation, as defined in Minnesota Rules, part 9505.0315, subpart 1, item F, if the provider receives and maintains a current physician's order by the recipient's attending physician certifying that the recipient is so mentally or physically impaired as to be unable to safely access and use a bus, taxi, other commercial transportation, or private automobile. The commissioner shall establish maximum medical assistance reimbursement rates for special transportation services for persons who need a wheelchair lift van or stretcher–equipped vehicle and for those who do not need a wheelchair lift van or stretcher–equipped vehicle. The average of these two rates must not exceed $14 for the base rate and $1.10 per mile. Special transportation provided to nonambulatory persons who do not need a wheelchair lift van or stretcher–equipped vehicle, may be reimbursed at a lower rate than special transportation provided to persons who need a wheelchair lift van or stretcher–equipped vehicle.

Subd. 18. **Bus or taxicab transportation.** To the extent authorized by rule of the state agency, medical assistance covers costs of the most appropriate and cost–effective form of transportation incurred by any ambulatory eligible person for obtaining nonemergency medical care.

Subd. 18a. **Payment for meals and lodging.** (a) Medical assistance reimbursement for meals for persons traveling to receive medical care may not exceed $5.50 for breakfast, $6.50 for lunch, or $8 for dinner.

(b) Medical assistance reimbursement for lodging for persons traveling to receive medical care may not exceed $50 per day unless prior authorized by the local agency.

(c) Medical assistance direct mileage reimbursement to the eligible person or the eligible person's driver may not exceed 20 cents per mile.

Subd. 19a. **Personal care services.** Medical assistance covers personal care services in a recipient's home. To qualify for personal care services recipients must be able to identify their needs, direct and evaluate task accomplishment, and assure their health and safety. Approved hours may be used outside the home when normal life activities take them outside the home and when, without the provision of personal care, their health and safety would be jeopardized. Total hours for services, whether actually performed inside or outside the recipient's home, cannot exceed that which is otherwise allowed for personal care services in an in–home setting according to section 256B.0627. Medical assistance does not cover personal care 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 services or forgoes the facility per diem for the leave days that personal care services are used. All personal care services must be provided according to section 256B.0627. Personal care services may not be reimbursed if the personal care assistant is the spouse or legal guardian of the recipient or the parent of a recipient under age 18. Parents of adult recipients, adult children of the recipient or adult siblings of the recipient may be reimbursed for personal care services if they are not the recipient's legal guardian and are granted a waiver under section 256B.0627.

[For text of subds 19b to 29, see M.S.1994]

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

(b) A federally qualified health center that is beginning initial operation shall submit an estimate of budgeted costs and visits for the initial reporting period in the form and detail required by the commissioner. A federally qualified health center that is already in operation shall submit an initial report using actual costs and visits for the initial reporting period. Within 90 days of the end of its reporting period, a federally qualified health center shall submit, in the form and detail required by the commissioner, a report of its operations, including

allowable costs actually incurred for the period and the actual number of visits for services furnished during the period, and other information required by the commissioner. Federally qualified health centers that file Medicare cost reports shall provide the commissioner with a copy of the most recent Medicare cost report filed with the Medicare program intermediary for the reporting year which support the costs claimed on their cost report to the state.

(c) In order to continue cost–based payment under the medical assistance program according to paragraphs (a) and (b), a federally qualified health center or rural health clinic must apply for designation as an essential community provider within six months of final adoption of rules by the department of health according to section 62Q.19, subdivision 7. For those federally qualified health centers and rural health clinics that have applied for essential community provider status within the six–month time prescribed, medical assistance payments will continue to be made according to paragraphs (a) and (b) for the first three years of essential community provider status. For federally qualified health centers and rural health clinics that either do not apply within the time specified above, that are denied essential community provider status by the department of health, or who have had essential community provider status for three years, medical assistance payments for health services provided by these entities shall be according to the same rates and conditions applicable to the same service provided by health care providers that are not federally qualified health centers or rural health clinics. This paragraph takes effect only if the Minnesota health care reform waiver is approved by the federal government, and remains in effect for as long as the Minnesota health care reform waiver remains in effect. When the waiver expires, this paragraph expires, and the commissioner of human services shall publish a notice in the State Register and notify the revisor of statutes.

[For text of subds 31 to 36, see M.S.1994]

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.

Subd. 39. **Childhood immunizations.** Providers who administer pediatric vaccines within the scope of their licensure, and who are enrolled as a medical assistance provider, must enroll in the pediatric vaccine administration program established by section 13631 of the Omnibus Budget Reconciliation Act of 1993. Medical assistance shall pay an $8.50 fee per dose for administration of the vaccine to children eligible for medical assistance. Medical assistance does not pay for vaccines that are available at no cost from the pediatric vaccine administration program.

Subd. 40. **Tuberculosis related services.** (a) For persons infected with tuberculosis, medical assistance covers case management services and direct observation of the intake of drugs prescribed to treat tuberculosis.

(b) "Case management services" means services furnished to assist persons infected with tuberculosis in gaining access to needed medical services. Case management services include at a minimum:

(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.

History: *1995 c 178 art 2 s 26; 1995 c 207 art 6 s 38–51; art 8 s 33; 1995 c 263 s 10*

NOTE: The amendment to subdivision 19a by Laws 1995, chapter 207, article 6, section 48, is effective July 1, 1996. See Laws 1995, chapter 207, article 6, section 125, subdivision 8.

256B.0627 COVERED SERVICE; HOME CARE SERVICES.

Subdivision 1. **Definition.** (a) "Home care services" means a health service, determined by the commissioner as medically necessary, that is ordered by a physician and documented in a care plan that is reviewed by the physician at least once every 60 days for the provision of home health services, or private duty nursing, or at least once every 365 days for personal care. Home care services are provided to the recipient at the recipient's residence that is a place other than a hospital or long–term care facility or as specified in section 256B.0625.

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

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

(d) "Assessment" means a review and evaluation of a recipient's need for home care services conducted in person. Assessments for private duty nursing shall be conducted by a private duty nurse. Assessments for home health agency services shall be conducted by a home health agency nurse. Assessments for personal care services shall be conducted by the county public health nurse or a certified public health nurse under contract with the county. Assessments must be completed on forms provided by the commissioner within 30 days of a request for home care services by a recipient or responsible party.

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

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

(g) "Personal care assistant" means a person who: (1) is at least 18 years old; (2) is able to read, write, and speak English, or communicate with sign language, as well as communicate with the recipient; (3) effective July 1, 1996, has completed one of the training requirements as specified in Minnesota Rules, part 9505.0335, subpart 3, items A to D; (4) has the ability to, and provides covered personal care services according to the recipient's care plan; (5) is not a consumer of personal care services; and (6) is subject to criminal background checks. An individual who has ever been convicted of a crime specified in Minnesota Rules,

part 4668.0020, subpart 14, or a comparable crime in another jurisdiction is disqualified from being a personal care assistant.

(h) "Personal care provider organization" means an organization enrolled to provide personal care services under the medical assistance program that complies with the following: (1) owners who have a five percent interest or more are subject to a criminal history check as provided in section 245A.04 at the time of application. An organization will be barred from enrollment if an owner or managerial official of the organization has ever been convicted of a crime specified in Minnesota Rules, part 4668.0020, subpart 14, or a comparable crime in another jurisdiction; (2) the organization must maintain a surety bond and liability insurance throughout the duration of enrollment and provides proof thereof. The insurer must notify the department of human services of the cancellation or lapse of policy; and (3) the organization must maintain documentation of services as specified in Minnesota Rules, part 9505.2175, subpart 7, as well as evidence of compliance with personal care assistant training requirements.

NOTE: The amendments to section 256B.0627, subdivision 1, by Laws 1995, chapter 207, article 6, section 52, shown above (paragraph (d), "assessment," and paragraph (e), "service plan,") are effective January 1, 1996. See Laws 1995, chapter 207, article 6, section 125, subdivision 9.

NOTE: For amendments to section 256B.0627, subdivision 1, effective July 1, 1995, see Laws 1995, chapter 207, article 6, section 52.

NOTE: Pursuant to Laws 1995, chapter 207, article 6, section 125, subdivision 9, on July 1, 1996, section 256B.0627, subdivision 1, as amended by Laws 1995, chapter 207, article 6, section 52, will read as follows:

"Subdivision 1. **Definition.** (a) "Assessment" means a review and evaluation of a recipient's need for home care services conducted in person. Assessments for private duty nursing shall be conducted by a private duty nurse. Assessments for home health agency services shall be conducted by a home health agency nurse. Assessments for personal care services shall be conducted by the county public health nurse or a certified public health nurse under contract with the county. Assessments must be completed on forms provided by the commissioner within 30 days of a request for home care services by a recipient or responsible party.

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

(c) "Home care services" means a health service, determined by the commissioner as medically necessary, that is ordered by a physician and documented in a care plan that is reviewed by the physician at least once every 60 days for the provision of home health services, or private duty nursing, or at least once every 365 days for personal care. Home care services are provided to the recipient at the recipient's residence that is a place other than a hospital or long-term care facility or as specified in section 256B.0625.

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

(e) "Personal care assistant" means a person who: (1) is at least 18 years old; (2) is able to read, write, and speak English, or communicate with sign language, as well as communicate with the recipient; (3) effective July 1, 1996, has completed one of the training requirements as specified in Minnesota Rules, part 9505.0335, subpart 3, items A to D; (4) has the ability to, and provides covered personal care services according to the recipient's care plan; (5) is not a consumer of personal care services; and (6) is subject to criminal background checks. An individual who has ever been convicted of a crime specified in Minnesota Rules, part 4668.0020, subpart 14, or a comparable crime in another jurisdiction is disqualified from being a personal care assistant.

(f) "Personal care provider organization" means an organization enrolled to provide personal care services under the medical assistance program that complies with the following: (1) owners who have a five percent interest or more are subject to a criminal history check as provided in section 245A.04 at the time of application. An organization will be barred from enrollment if an owner or managerial official of the organization has ever been convicted of a crime specified in Minnesota Rules, part 4668.0020, subpart 14, or a comparable crime in another jurisdiction; (2) the organization must maintain a surety bond and liability insurance throughout the duration of enrollment and provides proof thereof. The insurer must notify the department of human services of the cancellation or lapse of policy; and (3) the organization must maintain documentation of services as specified in Minnesota Rules, part 9505.2175, subpart 7, as well as evidence of compliance with personal care assistant training requirements.

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

Subd. 2. **Services covered.** Home care services covered under this section include:

(1) nursing services under section 256B.0625, subdivision 6a;

(2) private duty nursing services under section 256B.0625, subdivision 7;

(3) home health aide services under section 256B.0625, subdivision 6a;

(4) personal care services under section 256B.0625, subdivision 19a;

(5) nursing supervision of personal care services under section 256B.0625, subdivision 19a; and

(6) assessments by county public health nurses for services under section 256B.0625, subdivision 19a.

NOTE: The above amendment to section 256B.0627, subdivision 2, by Laws 1995, chapter 207, article 6, section 53, adding clause (6), is effective January 1, 1996. See Laws 1995, chapter 207, article 6, section 125, subdivision 10.

Subd. 4. **Personal care services.** (a) The personal care services that are eligible for payment are the following:

(1) bowel and bladder care;

(2) skin care to maintain the health of the skin;

(3) delegated therapy tasks specific to maintaining a recipient's optimal level of functioning, including range of motion and muscle strengthening exercises;

(4) respiratory assistance;

(5) transfers and ambulation;

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

(7) turning and positioning;

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

(9) application and maintenance of prosthetics and orthotics;

(10) cleaning medical equipment;

(11) dressing or undressing;

(12) assistance with food, nutrition, and diet activities;

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

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

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

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

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

(18) incidental household services that are an integral part of a personal care service described in clauses (1) to (17).

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

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

(1) personal care services that are not in the care plan developed by the supervising registered nurse in consultation with the personal care assistants and the recipient or the responsible party directing the care of the recipient;

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

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

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

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

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

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

(8) sterile procedures;

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

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

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

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

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

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

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

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

(12) home maintenance, or chore services;

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

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

NOTE: The above amendment to section 256B.0627, subdivision 4, by Laws 1995, chapter 207, article 6, section 54, is effective January 1, 1996. See Laws 1995, chapter 207, article 6, section 125, subdivision 11.

NOTE: Pursuant to Laws 1995, chapter 207, article 6, section 125, subdivision 11, on July 1, 1996, section 256B.0627, subdivision 4, as amended by Laws 1995, chapter 207, article 6, section 54, will read as follows:

"Subd. 4. **Personal care services.** (a) The personal care services that are eligible for payment are the following:

(1) bowel and bladder care;

(2) skin care to maintain the health of the skin;

(3) repetitive maintenance range of motion and muscle strengthening exercises specific to maintaining a recipient's optimal level of function;

(4) respiratory assistance;

(5) transfers and ambulation;

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

(7) turning and positioning;

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

(9) application and maintenance of prosthetics and orthotics;

(10) cleaning medical equipment;

(11) dressing or undressing;

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

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

(14) incidental household services that are an integral part of a personal care service described in clauses (1) to (13).

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

(1) services not ordered by the physician;

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

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

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

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

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

(7) sterile procedures;

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

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

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

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

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

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

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

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

(11) home maintenance, or chore services;

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

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

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

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

(1) a total of 40 home health aide visits or skilled nurse visits under section 256B.0625, subdivision 6a; and

(2) assessments and reassessments done to determine a recipient's need for personal care services.

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

(1) the home care services were required to treat an emergency medical condition that if not immediately treated could cause a recipient serious physical or mental disability, continuation of severe pain, or death. The provider must request retroactive authorization no later than five working days after giving the initial service. The provider must be able to substantiate the emergency by documentation such as reports, notes, and admission or discharge histories;

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

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

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

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

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

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

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

(3) To continue to receive personal care services when the recipient displays no significant change, the county public health nurse has the option to review with the commissioner, or the commissioner's designee, the service plan on record and receive authorization for up to an additional 12 months.

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

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

(2) **Personal care services.** (i) All personal care services and registered nurse supervision must be prior authorized by the commissioner or the commissioner's designee except

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

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

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

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

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

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

(F) a reasonable amount of time for the necessary provision of nursing supervision of personal care services.

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

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

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

(A) daily tube feedings;

(B) daily parenteral therapy;

(C) wound or decubiti care;

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

(E) catheterization;

(F) ostomy care;

(G) quadriplegia; or

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

(v) A recipient shall qualify as having Level I behavior if there is reasonable supporting evidence that the recipient exhibits, or that without supervision, observation, or redirection

would exhibit, one or more of the following behaviors that cause, or have the potential to cause:

(A) injury to his or her own body;

(B) physical injury to other people; or

(C) destruction of property.

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

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

(A) unusual or repetitive habits;

(B) withdrawn behavior; or

(C) offensive behavior.

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

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

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

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

The commissioner may authorize:

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

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

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

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

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

(f) **Prior authorization; time limits.** The commissioner or the commissioner's designee shall determine the time period for which a prior authorization shall be effective. If the recipient continues to require home care services beyond the duration of the prior authorization, the home care provider must request a new prior authorization. Under no circumstances, other than the exceptions in paragraph (b), shall a prior authorization be valid prior to the date the commissioner receives the request or for more than 12 months. A recipient who appeals a reduction in previously authorized home care services may continue previously authorized services, other than temporary services under paragraph (h), pending an appeal under section 256.045. The commissioner must provide a detailed explanation of why the authorized services are reduced in amount from those requested by the home care provider.

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

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

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

The commissioner may not authorize:

(1) home care services that are the responsibility of the foster care provider under the terms of the foster care placement agreement and administrative rules;

(2) personal care services when the foster care license holder is also the personal care provider or personal care assistant unless the recipient can direct the recipient's own care, or case management is provided as required in section 256B.0625, subdivision 19a;

(3) personal care services when the responsible party is an employee of, or under contract with, or has any direct or indirect financial relationship with the personal care provider or personal care assistant, unless case management is provided as required in section 256B.0625, subdivision 19a;

(4) home care services when the number of foster care residents is greater than four; or

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

NOTE: The above amendment to section 256B.0627, subdivision 5, by Laws 1995, chapter 207, article 6, section 55, is effective January 1, 1996. See Laws 1995, chapter 207, article 6, section 125, subdivision 12.

NOTE: For amendments to section 256B.0627, subdivision 5, effective July 1, 1995, see Laws 1995, chapter 207, article 6, section 55.

NOTE: Pursuant to Laws 1995, chapter 207, article 6, section 125, subdivision 12, on July 1, 1996, section 256B.0627, subdivision 5, as amended by Laws 1995, chapter 207, article 6, section 55, will read as follows:

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

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

(1) a total of 40 home health aide visits or skilled nurse visits under section 256B.0625, subdivision 6a; and

(2) assessments and reassessments done to determine a recipient's need for personal care services.

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

(1) the home care services were required to treat an emergency medical condition that if not immediately treated could cause a recipient serious physical or mental disability, continuation of severe pain, or death. The provider must request retroactive authorization no later than five working days after giving the initial service. The provider must be able to substantiate the emergency by documentation such as reports, notes, and admission or discharge histories;

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

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

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

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

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

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

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

(3) To continue to receive personal care services when the recipient displays no significant change, the county public health nurse has the option to review with the commissioner, or the commissioner's designee, the service plan on record and receive authorization for up to an additional 12 months.

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

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

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

(A) up to 1.75 times the average number of direct care hours provided in nursing facilities for the recipient's comparable case mix level; or

(B) up to 2.625 times the average number of direct care hours provided in nursing facilities for recipients who have complex medical needs or are dependent in at least seven activities of daily living and need physical assistance with eating or have a neurological diagnosis but in no case shall the dollar amount authorized exceed the statewide weighted average nursing facility payment rate for fiscal year 1995; or

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

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

(E) a reasonable amount of time for the provision of nursing supervision of personal care services.

(ii) The number of direct care hours shall be determined according to the annual cost report submitted to the department by nursing facilities. The average number of direct care hours, for the report year 1993, as established by July 11, 1994, shall be calculated and incorporated into the home care limits on July 1, 1996. These limits shall be calculated to the nearest quarter hour.

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

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

(A) daily tube feedings;

(B) daily parenteral therapy;

(C) wound or decubiti care;

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

(E) catheterization;

(F) ostomy care;

(G) quadriplegia; or

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

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

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

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

The commissioner may authorize:

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

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

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

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

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

(f) **Prior authorization; time limits.** The commissioner or the commissioner's designee shall determine the time period for which a prior authorization shall be effective. If the recipient continues to require home care services beyond the duration of the prior authorization, the home care provider must request a new prior authorization. Under no circumstances, other than the exceptions in paragraph (b), shall a prior authorization be valid prior to the date the commissioner receives the request or for more than 12 months. A recipient who appeals a reduction in previously authorized home care services may continue previously authorized services, other than temporary services under paragraph (h), pending an appeal under section 256.045. The commissioner must provide a detailed explanation of why the authorized services are reduced in amount from those requested by the home care provider.

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

(h) **Prior authorization requests; temporary services.** The agency nurse, the independently enrolled private duty nurse, or county public health nurse may request a temporary authorization for home care services by telephone. The commissioner may approve a temporary level of home care services based on the assessment and service or care plan information. Authorization for a

temporary level of home care services including nurse supervision is limited to the time specified by the commissioner, but shall not exceed 45 days, unless extended because the county public health nurse has not completed the required assessment and service plan, or the commissioner's determination has not been made. The level of services authorized under this provision shall have no bearing on a future prior authorization.

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

The commissioner may not authorize:

(1) home care services that are the responsibility of the foster care provider under the terms of the foster care placement agreement and administrative rules;

(2) home care services when the number of foster care residents is greater than four; or

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

[For text of subd 6, see M.S.1994]

History: *1995 c 207 art 6 s 52–55*

256B.0628 PRIOR AUTHORIZATION AND REVIEW OF HOME CARE SERVICES.

[For text of subd 1, see M.S.1994]

Subd. 2. **Duties.** (a) The commissioner may contract with or employ qualified registered nurses and necessary support staff, or contract with qualified agencies, to provide home care prior authorization and review services for medical assistance recipients who are receiving home care services.

(b) Reimbursement for the prior 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 service plan that meets the recipient's needs is developed by the appropriate agency or individual;

(3) ensure cost–effectiveness 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; and

(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.

(c) In addition, the commissioner or the commissioner's designee may:

(1) review 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; and

(5) assure the quality of 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. **Assessment and prior authorization process for recipients of both home care and home and community–based waivered services for persons with mental retardation or related conditions.** Effective January 1, 1996, for purposes of providing in-

formed choice, coordinating of local planning decisions, and streamlining administrative requirements, the assessment and prior authorization process for persons receiving both home care and home and community–based waivered services for persons with mental retardation or related conditions shall meet the requirements of this section and section 256B.0627 with the following exceptions:

(a) Upon request for home care services and subsequent assessment by the public health nurse under section 256B.0627, 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 prior 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 mental retardation or related conditions.

(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 prior authorization process will be held separate and distinct from the provision of services.

History: *1995 c 207 art 3 s 18; art 6 s 56*

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; and

(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.

[For text of subds 2 and 3, see M.S.1994]

History: *1995 c 207 art 7 s 22*

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

A vendor of medical care, as defined in section 256B.02, subdivision 7, and a health maintenance organization, as defined in chapter 62D, must participate as a provider or contractor in the medical assistance program, general assistance medical care program, and MinnesotaCare as a condition of participating as a provider in health insurance plans and pro-

grams 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.16. The limitations on insurance plans offered to local government employees shall not be applicable in geographic areas where provider participation is limited by managed care contracts with the department of human services. For providers other than health maintenance organizations, participation in the medical assistance program means that (1) the provider accepts new medical assistance, general assistance medical care, and MinnesotaCare patients or (2) at least 20 percent of the provider's patients are covered by medical assistance, general assistance medical care, and MinnesotaCare as their primary source of coverage. The commissioner shall establish participation requirements for health maintenance organizations. The commissioner shall provide lists of participating medical assistance providers on a quarterly basis to the commissioner of employee relations, the commissioner of labor and industry, and the commissioner of commerce. Each of the commissioners shall develop and implement procedures to exclude as participating providers in the program or programs under their jurisdiction those providers who do not participate in the medical assistance program. The commissioner of employee relations shall implement this section through contracts with participating health and dental carriers.

History: *1995 c 248 art 10 s 16*

256B.0645 PROVIDER PAYMENTS; RETROACTIVE CHANGES IN ELIGIBILITY.

Payment to a provider for a health care service provided to a general assistance medical care recipient who is later determined eligible for medical assistance or MinnesotaCare according to section 256.9367 for the period in which the health care service was provided, shall be considered payment in full, and shall not be adjusted due to the change in eligibility. This section applies to both fee–for–service payments and payments made to health plans on a prepaid capitated basis.

History: *1995 c 234 art 6 s 39*

256B.0911 NURSING FACILITY PREADMISSION SCREENING.

[For text of subd 1, see M.S.1994]

Subd. 2. **Persons required to be screened; exemptions.** All applicants to Medicaid certified nursing facilities must be screened prior to admission, regardless of income, assets, or funding sources, except the following:

(1) patients who, having entered acute care facilities from certified nursing facilities, are returning to a certified nursing facility;

(2) residents transferred from other certified nursing facilities located within the state of Minnesota;

(3) individuals who have a contractual right to have their nursing facility care paid for indefinitely by the veteran's administration;

(4) individuals who are enrolled in the Ebenezer/Group Health social health maintenance organization project, or enrolled in a demonstration project under section 256B.69, subdivision 18, at the time of application to a nursing home; or

(5) individuals previously screened and currently being served under the alternative care program or under a home and community–based services waiver authorized under section 1915(c) of the Social Security Act.

Regardless of the exemptions in clauses (2) to (4), persons who have a diagnosis or possible diagnosis of mental illness, mental retardation, or a related condition must be screened before admission unless the admission prior to screening is authorized by the local mental health authority or the local developmental disabilities case manager, or unless authorized by the county agency according to Public Law Number 101–508.

Before admission to a Medicaid certified nursing home or boarding care home, all persons must be screened and approved for admission through an assessment process. The nurs-

ing facility is authorized to conduct case mix assessments which are not conducted by the county public health nurse under Minnesota Rules, part 9549.0059. The designated county agency is responsible for distributing the quality assurance and review form for all new applicants to nursing homes.

Other persons who are not applicants to nursing facilities must be screened if a request is made for a screening.

Subd. 2a. **Screening requirements.** Persons may be screened by telephone or in a face–to–face consultation. The screener will identify each individual's needs according to the following categories: (1) needs no face–to–face screening; (2) needs an immediate face–to–face screening interview; or (3) needs a face–to–face screening interview after admission to a certified nursing facility or after a return home. The screener shall confer with the screening team to ensure that the health and social needs of the individual are assessed. Persons who are not admitted to a Medicaid certified nursing facility must be screened within ten working days after the date of referral. Persons admitted on a nonemergency basis to a Medicaid certified nursing facility must be screened prior to the certified nursing facility admission. Persons admitted to the Medicaid certified nursing facility from the community on an emergency basis or from an acute care facility on a nonworking day must be screened the first working day after admission and the reason for the emergency admission must be certified by the attending physician in the person's medical record.

Subd. 3. **Persons responsible for conducting the preadmission screening.** (a) A local screening team shall be established by the county board of commissioners. Each local screening team shall consist of screeners who are a social worker and a public health nurse from their respective county agencies. If a county does not have a public health nurse available, it may request approval from the commissioner to assign a county registered nurse with at least one year experience in home care to participate on the team. The screening team members must confer regarding the most appropriate care for each individual screened. Two or more counties may collaborate to establish a joint local screening team or teams.

(b) In assessing a person's needs, screeners shall have a physician available for consultation and shall consider the assessment of the individual's attending physician, if any. The individual's physician shall be included if the physician chooses to participate. Other personnel may be included on the team as deemed appropriate by the county agencies.

Subd. 4. **Responsibilities of the county and the screening team.** (a) The county shall:

(1) provide information and education to the general public regarding availability of the preadmission screening program;

(2) accept referrals from individuals, families, human service and health professionals, and hospital and nursing facility personnel;

(3) assess the health, psychological, and social needs of referred individuals and identify services needed to maintain these persons in the least restrictive environments;

(4) determine if the individual screened needs nursing facility level of care;

(5) assess specialized service needs based upon an evaluation by:

(i) a qualified independent mental health professional for persons with a primary or secondary diagnosis of a serious mental illness; and

(ii) a qualified mental retardation professional for persons with a primary or secondary diagnosis of mental retardation or related conditions. For purposes of this clause, a qualified mental retardation professional must meet the standards for a qualified mental retardation professional in Code of Federal Regulations, title 42, section 483.430;

(6) make recommendations for individuals screened regarding cost–effective community services which are available to the individual;

(7) make recommendations for individuals screened regarding nursing home placement when there are no cost–effective community services available;

(8) develop an individual's community care plan and provide follow–up services as needed; and

(9) prepare and submit reports that may be required by the commissioner of human services.

(b) The screener shall document that the most cost–effective alternatives available were offered to the individual or the individual's legal representative. For purposes of this section,

"cost–effective alternatives" means community services and living arrangements that cost the same or less than nursing facility care.

(c) Screeners shall adhere to the level of care criteria for admission to a certified nursing facility established under section 144.0721.

(d) For persons who are eligible for medical assistance or who would be eligible within 180 days of admission to a nursing facility and who are admitted to a nursing facility, the nursing facility must include a screener or the case manager in the discharge planning process for those individuals who the team has determined have discharge potential. The screener or the case manager must ensure a smooth transition and follow–up for the individual's return to the community.

Screeners shall cooperate with other public and private agencies in the community, in order to offer a variety of cost–effective services to the disabled and elderly. The screeners shall encourage the use of volunteers from families, religious organizations, social clubs, and similar civic and service organizations to provide services.

[For text of subds 5 and 6, see M.S.1994]

Subd. 7. **Reimbursement for certified nursing facilities.** (a) Medical assistance reimbursement for nursing facilities shall be authorized for a medical assistance recipient only if a preadmission screening has been conducted prior to admission or the local county agency has authorized an exemption. Medical assistance reimbursement for nursing facilities shall not be provided for any recipient who the local screener has determined does not meet the level of care criteria for nursing facility placement or, if indicated, has not had a level II PASARR evaluation completed unless an admission for a recipient with mental illness is approved by the local mental health authority or an admission for a recipient with mental retardation or related condition is approved by the state mental retardation authority. The county preadmission screening team may deny certified nursing facility admission using the level of care criteria established under section 144.0721 and deny medical assistance reimbursement for certified nursing facility care. Persons receiving care in a certified nursing facility or certified boarding care home who are reassessed and no longer meet the level of care criteria for a certified nursing facility or certified boarding care home may no longer remain a resident in the certified nursing facility or certified boarding care home and must be relocated to the community if the persons were admitted on or after July 1, 1996. Persons receiving services under section 256B.0913, subdivisions 1 to 14, or 256B.0915 who are reassessed and found to not meet the level of care criteria for admission to a certified nursing facility or certified boarding care home may no longer receive these services after July 1, 1996. The commissioner shall make a request to the health care financing administration for a waiver allowing screening team approval of Medicaid payments for certified nursing facility care. An individual has a choice and makes the final decision between nursing facility placement and community placement after the screening team's recommendation, except as provided in paragraphs (b) and (c).

(b) The local county mental health authority or the state mental retardation authority under Public Law Numbers 100–203 and 101–508 may prohibit admission to a nursing facility, if the individual does not meet the nursing facility level of care criteria or needs specialized services as defined in Public Law Numbers 100–203 and 101–508. For purposes of this section, "specialized services" for a person with mental retardation or a related condition means "active treatment" as that term is defined in Code of Federal Regulations, title 42, section 483.440(a)(1).

(c) Upon the receipt by the commissioner of approval by the Secretary of Health and Human Services of the waiver requested under paragraph (a), the local screener shall deny medical assistance reimbursement for nursing facility care for an individual whose long–term care needs can be met in a community–based setting and whose cost of community–based home care services is less than 75 percent of the average payment for nursing facility care for that individual's case mix classification, and who is either:

(i) a current medical assistance recipient being screened for admission to a nursing facility; or

(ii) an individual who would be eligible for medical assistance within 180 days of entering a nursing facility and who meets a nursing facility level of care.

(d) Appeals from the screening team's recommendation or the county agency's final decision shall be made according to section 256.045, subdivision 3.

[For text of subds 8 and 9, see M.S.1994]

History: *1995 c 207 art 6 s 57–61*

256B.0912 ALTERNATIVE CARE AND WAIVERED SERVICE PROGRAMS.

Subdivision 1. **Restructuring plan.** By January 1, 1996, the commissioner shall present a plan to the legislature to restructure administration of the alternative care, elderly waiver, and disabled waiver programs. The plan must demonstrate cost neutrality and provide counties with the flexibility, authority, and accountability to administer home and community–based service programs within predetermined fixed budgets. To support this local program administration, the commissioner shall explore options with the health care financing administration to assure flexibility to expand core services within the elderly and disabled waivers as long as cost neutrality is maintained.

Subd. 2. **Waiver program modifications.** The commissioner of human services shall make the following modifications in medical assistance waiver programs, effective for services rendered after June 30, 1995, or, if necessary, after federal approval is granted:

(a) The community alternatives for disabled individuals waiver shall:

(1) if medical supplies and equipment or adaptations are or will be purchased for a waiver services recipient, allow the prorating of costs on a monthly basis throughout the year in which they are purchased. If the monthly cost of a recipient's other waivered services exceeds the monthly limit established in this paragraph, the annual cost of the waivered services shall be determined. In this event, the annual cost of waivered services shall not exceed 12 times the monthly limit calculated in this paragraph;

(2) require client reassessments once every 12 months;

(3) permit the purchase of supplies and equipment costing $150 or less without prior approval of the commissioner of human services. A county is not required to contract with a provider of supplies and equipment if the monthly cost of supplies and equipment is less than $250; and

(4) allow the implementation of care plans without the approval of the county of financial responsibility when the client receives services from another county.

(b) The traumatic brain injury waiver shall:

(1) require client reassessments once every 12 months;

(2) permit the purchase of supplies and equipment costing $250 or less without having a contract with the supplier; and

(3) allow the implementation of care plans without the approval of the county of financial responsibility when the client receives services from another county.

History: *1995 c 207 art 6 s 62*

256B.0913 ALTERNATIVE CARE PROGRAM.

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

Subd. 4. **Eligibility for funding for services for nonmedical assistance recipients.** (a) Funding for services under the alternative care program is available to persons who meet the following criteria:

(1) the person has been screened by the county screening team or, if previously screened and served under the alternative care program, assessed by the local county social worker or public health nurse;

(2) the person is age 65 or older;

(3) the person would be financially eligible for medical assistance within 180 days of admission to a nursing facility;

(4) the person meets the asset transfer requirements of the medical assistance program;

(5) the screening team would recommend nursing facility admission or continued stay for the person if alternative care services were not available;

(6) the person needs services that are not available at that time in the county through other county, state, or federal funding sources; and

(7) the monthly cost of the alternative care services funded by the program for this person does not exceed 75 percent of the statewide average monthly medical assistance payment for nursing facility care at the individual's case mix classification to which the individual would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059. If medical supplies and equipment or adaptations are or will be purchased for an alternative care services recipient, the costs may be prorated on a monthly basis throughout the year in which they are purchased. 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 calculated in this paragraph.

(b) Individuals who meet the criteria in paragraph (a) and who have been approved for alternative care funding are called 180–day eligible clients.

(c) The statewide average payment for nursing facility care is the statewide average monthly nursing facility rate in effect on July 1 of the fiscal year in which the cost is incurred, less the statewide average monthly income of nursing facility residents who are age 65 or older and who are medical assistance recipients in the month of March of the previous fiscal year. This monthly limit does not prohibit the 180–day eligible client from paying for additional services needed or desired.

(d) In determining the total costs of alternative care services for one month, the costs of all services funded by the alternative care program, including supplies and equipment, must be included.

(e) 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, unless authorized by the commissioner. A person whose application for medical assistance 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, the county must bill medical assistance from the date the individual was found eligible for services reimbursable under the elderly waiver program.

(f) Alternative care funding is not available for a person who resides in a licensed nursing home or boarding care home, except for case management services which are being provided in support of the discharge planning process.

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

(1) adult foster care;

(2) adult day care;

(3) home health aide;

(4) homemaker services;

(5) personal care;

(6) case management;

(7) respite care;

(8) assisted living;

(9) residential care services;

(10) care–related supplies and equipment;

(11) meals delivered to the home;

(12) transportation;

(13) skilled nursing;

(14) chore services;

(15) companion services;

(16) nutrition services; and

(17) training for direct informal caregivers.

(b) The county agency must ensure that the funds are used only to supplement and not supplant services available through other public assistance or services programs.

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

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

(e) Personal care services may be provided by a personal care provider organization. A county agency may contract with a relative of the client to provide personal care services, but must ensure nursing supervision. Covered personal care services defined in section 256B.0627, subdivision 4, must meet applicable standards in Minnesota Rules, part 9505.0335.

(f) Costs for supplies and equipment that exceed $150 per item per month must have prior approval from the commissioner. A county may use alternative care funds to purchase supplies and equipment from a non–Medicaid certified vendor if the cost for the items is less than that of a Medicaid vendor. A county is not required to contract with a provider of supplies and equipment if the monthly cost of the supplies and equipment is less than $250.

(g) For purposes of this section, residential care services are services which are provided to individuals living in residential care homes. Residential care homes are currently licensed as board and lodging establishments and are registered with the department of health as providing special services. Residential care services are defined as "supportive services" and "health–related services." "Supportive services" means the provision of up to 24–hour supervision and oversight. Supportive services includes: (1) transportation, when provided by the residential care center only; (2) socialization, when socialization is part of the plan of care, has specific goals and outcomes established, and is not diversional or recreational in nature; (3) assisting clients in setting up meetings and appointments; (4) assisting clients in setting up medical and social services; (5) providing assistance with personal laundry, such as carrying the client's laundry to the laundry room. Assistance with personal laundry does not include any laundry, such as bed linen, that is included in the room and board rate. Health–related services are limited to minimal assistance with dressing, grooming, and bathing and providing reminders to residents to take medications that are self–administered or providing storage for medications, if requested. Individuals receiving residential care services cannot receive both personal care services and residential care services.

(h) For the purposes of this section, "assisted living" refers to supportive services provided by a single vendor to clients who reside in the same apartment building of three or more units. Assisted living services are defined as up to 24–hour supervision, and oversight, supportive services as defined in clause (1), individualized home care aide tasks as defined in clause (2), and individualized home management tasks as defined in clause (3) provided to residents of a residential center living in their units or apartments with a full kitchen and bathroom. A full kitchen includes a stove, oven, refrigerator, food preparation counter space, and a kitchen utensil storage compartment. Assisted living services must be provided by the management of the residential center or by providers under contract with the management or with the county.

(1) Supportive services include:

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

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

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

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

(2) Home care aide tasks means:

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

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

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

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

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

(3) Home management tasks means:

(i) housekeeping;

(ii) laundry;

(iii) preparation of regular snacks and meals; and

(iv) shopping.

Assisted living services as defined in this section shall not be authorized in boarding and lodging establishments licensed according to sections 157.03 and 157.15 to 157.22.

(i) For the purposes of this section, reimbursement for assisted living services and residential care services shall be a monthly rate negotiated and authorized by the county agency. The rate shall not exceed the nonfederal share of the greater of either the statewide or any of the geographic groups' weighted average monthly medical assistance nursing facility payment rate of the case mix resident class to which the 180–day eligible client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059. For alternative care assisted living projects established under Laws 1988, chapter 689, article 2, section 256, monthly rates may not exceed 65 percent of the greater of either statewide or any of the geographic groups' weighted average monthly medical assistance nursing facility payment rate of the case mix resident class to which the 180–day eligible client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059. The rate may not cover rent and direct food costs.

(j) For purposes of this section, companion services are defined as nonmedical care, supervision and oversight, provided to a functionally impaired adult. Companions may assist the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands–on medical care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the recipient. This service must be approved by the case manager as part of the care plan. Companion services must be provided by individuals or nonprofit organizations who are under contract with the local agency to provide the service. Any person related to the waiver recipient by blood, marriage or adoption cannot be reimbursed under this service. Persons providing companion services will be monitored by the case manager.

(k) For purposes of this section, training for direct informal caregivers is defined as a classroom or home course of instruction which may include: transfer and lifting skills, nutrition, personal and physical cares, home safety in a home environment, stress reduction and management, behavioral management, long–term care decision making, care coordination and family dynamics. The training is provided to an informal unpaid caregiver of a 180–day eligible client which enables the caregiver to deliver care in a home setting with high levels of quality. The training must be approved by the case manager as part of the individual care plan. Individuals, agencies, and educational facilities which provide caregiver training and education will be monitored by the case manager.

[For text of subds 6 and 7, see M.S.1994]

Subd. 8. **Requirements for individual care plan.** (a) The case manager shall implement the plan of care for each 180–day eligible client and ensure that a client's service needs and eligibility are reassessed at least every 12 months. The plan shall include any services prescribed by the individual's attending physician as necessary to allow the individual to remain in a community setting. In developing the individual's care plan, the case manager should include the use of volunteers from families and neighbors, religious organizations,

social clubs, and civic and service organizations to support the formal home care services. The county shall be held harmless for damages or injuries sustained through the use of volunteers under this subdivision including workers' compensation liability. The lead agency shall provide documentation to the commissioner verifying that the individual's alternative care is not available at that time through any other public assistance or service program. The lead agency shall provide documentation in each individual's plan of care and 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. The case manager must give the individual a ten–day written notice of any decrease in or termination of alternative care services.

(b) If the county administering alternative care services is different than the county of financial responsibility, the care plan may be implemented without the approval of the county of financial responsibility.

[For text of subds 9 to 11, see M.S.1994]

Subd. 12. **Client premiums.** (a) A premium is required for all 180–day eligible clients to help pay for the cost of participating in the program. The amount of the premium for the alternative care client shall be determined as follows:

(1) when the alternative care client's income less recurring and predictable medical expenses is greater than the medical assistance income standard but less than 150 percent of the federal poverty guideline, and total assets are less than $6,000, the fee is zero;

(2) when the alternative care client's income less recurring and predictable medical expenses is greater than 150 percent of the federal poverty guideline, and total assets are less than $6,000, the fee is 25 percent of the cost of alternative care services or the difference between 150 percent of the federal poverty guideline and the client's income less recurring and predictable medical expenses, whichever is less; and

(3) when the alternative care client's total assets are greater than $6,000, the fee is 25 percent of the cost of alternative care services.

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

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

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

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

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

(2) a person is applying for medical assistance;

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

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

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

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

(c) The county agency must collect the premium from the client and forward the amounts collected to the commissioner in the manner and at the times prescribed by the commissioner. Money collected must be deposited in the general fund and is appropriated to the commissioner for the alternative care program. The client must supply the county with the client's social security number at the time of application. If a client fails or refuses to pay the premium due, the county shall supply the commissioner with the client's social security

number and other information the commissioner requires to collect the premium from the client. The commissioner shall collect unpaid premiums using the revenue recapture act in chapter 270A and other methods available to the commissioner. The commissioner may require counties to inform clients of the collection procedures that may be used by the state if a premium is not paid.

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

[For text of subd 13, see M.S.1994]

Subd. 14. **Reimbursement and rate adjustments.** (a) Reimbursement for expenditures for the alternative care services as approved by the client's case manager shall be through the invoice processing procedures of the department's Medicaid Management Information System (MMIS). To receive reimbursement, the county or vendor must submit invoices within 12 months following the date of service. The county agency and its vendors under contract shall not be reimbursed for services which exceed the county allocation.

(b) If a county collects less than 50 percent of the client premiums due under subdivision 12, the commissioner may withhold up to three percent of the county's final alternative care program allocation determined under subdivisions 10 and 11.

(c) Beginning July 1, 1991, the state will reimburse counties, up to the limits of state appropriations, according to the payment schedule in section 256.025 for the county share of costs incurred under this subdivision on or after January 1, 1991, for individuals who would be eligible for medical assistance within 180 days of admission to a nursing home.

(d) For fiscal years beginning on or after July 1, 1993, the commissioner of human services shall not provide automatic annual inflation adjustments for alternative care services. 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 adjustments in reimbursement rates for alternative care services based on the forecasted percentage change in the Home Health Agency Market Basket of Operating Costs, for the fiscal year beginning July 1, compared to the previous fiscal year, unless otherwise adjusted by statute. The Home Health Agency Market Basket of Operating Costs is published by Data Resources, Inc. The forecast to be used is the one published for the calendar quarter beginning January 1, six months prior to the beginning of the fiscal year for which rates are set.

(e) The county shall negotiate individual rates with vendors and may be reimbursed for actual costs up to the greater of the county's current approved rate or 60 percent of the maximum rate in fiscal year 1994 and 65 percent of the maximum rate in fiscal year 1995 for each alternative care service. Notwithstanding any other rule or statutory provision to the contrary, the commissioner shall not be authorized to increase rates by an annual inflation factor, unless so authorized by the legislature.

(f) On July 1, 1993, the commissioner shall increase the maximum rate for home delivered meals to $4.50 per meal.

Subd. 15. **Service allowance fund availability.** (a) Effective July 1, 1996, the commissioner may use alternative care funds for services to high function class A persons as defined in section 144.0721, subdivision 3, clause (2). The county alternative care grant allocation will be supplemented with a special allocation amount based on the projected number of eligible high function class A's and computed on the basis of $240 per month per projected eligible person. Individual monthly expenditures under the service allowance option are permitted to be either greater or less than the amount of $240 per month based on individual need. County allocations shall be adjusted periodically based on the actual provision of services to high function class A persons.

(b) Counties shall have the option of providing services, cash service allowances, vouchers, or a combination of these options to high function class A persons defined in section 144.0721, subdivision 3, clause (2). High function class A persons may choose services from among the categories of services listed under subdivision 5, except for case management services.

(c) If the allocation to a county is not sufficient to serve all persons who qualify for alternative care services, the county is not required to provide any alternative care services to a

high function class A person but shall establish a waiting list to provide services as funding becomes available.

Subd. 15a. **Reimbursement rate; Anoka county.** Notwithstanding subdivision 14, paragraph (e), or any other law to the contrary, for services rendered on or after January 1, 1996, Anoka county may pay vendors, and the commissioner shall reimburse the county, for actual costs up to a limit which is the maximum rate in effect on December 31, 1995, plus half the difference between that rate and the maximum allowed state rate for home health aide and homemaker services.

History: *1995 c 207 art 6 s 63–69; art 9 s 60; 1995 c 263 s 8*

256B.0915 MEDICAID WAIVER FOR HOME AND COMMUNITY-BASED SERVICES.

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

Subd. 2. **Spousal impoverishment policies.** The commissioner shall seek to amend the federal waiver and the medical assistance state plan to allow spousal impoverishment criteria as authorized under United States Code, title 42, section 1396r–5, and as implemented in sections 256B.0575, 256B.058, and 256B.059, except that the amendment shall seek to add to the personal needs allowance permitted in section 256B.0575, an amount equivalent to the group residential housing rate as set by section 256I.03, subdivision 5.

Subd. 3. **Limits of cases, rates, reimbursement, and forecasting.** (a) The number of medical assistance waiver recipients that a county may serve must be allocated according to the number of medical assistance waiver cases open on July 1 of each fiscal year. Additional recipients may be served with the approval of the commissioner.

(b) The monthly limit for the cost of waivered services to an individual waiver client shall be the statewide average payment rate of the case mix resident class to which the waiver client would be assigned under the medical assistance case mix reimbursement system. If medical supplies and equipment or adaptations are or will be purchased for an elderly waiver services recipient, the costs may be prorated on a monthly basis throughout the year in which they are purchased. If the monthly cost of a recipient's other waivered services exceeds the monthly limit established in this paragraph, the annual cost of the waivered services shall be determined. In this event, the annual cost of waivered services shall not exceed 12 times the monthly limit calculated in this paragraph. The statewide average payment rate is calculated by determining the statewide average monthly nursing home rate, effective July 1 of the fiscal year in which the cost is incurred, less the statewide average monthly income of nursing home residents who are age 65 or older, and who are medical assistance recipients in the month of March of the previous state fiscal year. The annual cost divided by 12 of elderly or disabled waivered services for a person who is a nursing facility resident at the time of requesting a determination of eligibility for elderly or disabled waivered services shall not exceed the monthly payment for the resident class assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, for that resident in the nursing facility where the resident currently resides. The following costs must be included in determining the total monthly costs for the waiver client:

(1) cost of all waivered services, including extended medical supplies and equipment; and

(2) cost of skilled nursing, home health aide, and personal care services reimbursable by medical assistance.

(c) Medical assistance funding for skilled nursing services, home health aide, and personal care services for waiver recipients must be approved by the case manager and included in the individual care plan.

(d) Expenditures for extended medical supplies and equipment that cost over $150 per month for both the elderly waiver and the disabled waiver must have the commissioner's prior approval. A county is not required to contract with a provider of supplies and equipment if the monthly cost of the supplies and equipment is less than $250.

(e) For the fiscal year beginning on July 1, 1993, and for subsequent fiscal years, the commissioner of human services shall not provide automatic annual inflation adjustments

for home and community–based waivered services. 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 adjustments in reimbursement rates for home and community–based waivered services, based on the forecasted percentage change in the Home Health Agency Market Basket of Operating Costs, for the fiscal year beginning July 1, compared to the previous fiscal year, unless otherwise adjusted by statute. The Home Health Agency Market Basket of Operating Costs is published by Data Resources, Inc. The forecast to be used is the one published for the calendar quarter beginning January 1, six months prior to the beginning of the fiscal year for which rates are set. The adult foster care rate shall be considered a difficulty of care payment and shall not include room and board.

(f) The adult foster care daily rate for the elderly and disabled waivers shall be negotiated between the county agency and the foster care provider. The rate established under this section shall not exceed the state average monthly nursing home payment for the case mix classification to which the individual receiving foster care is assigned; the rate must allow for other waiver and medical assistance home care services to be authorized by the case manager.

(g) The assisted living and residential care service rates for elderly and community alternatives for disabled individuals (CADI) waivers shall be made to the vendor as a monthly rate negotiated with the county agency. The rate shall not exceed the nonfederal share of the greater of either the statewide or any of the geographic groups' weighted average monthly medical assistance nursing facility payment rate of the case mix resident class to which the elderly or disabled client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059. For alternative care assisted living projects established under Laws 1988, chapter 689, article 2, section 256, monthly rates may not exceed 65 percent of the greater of either the statewide or any of the geographic groups' weighted average monthly medical assistance nursing facility payment rate for the case mix resident class to which the elderly or disabled client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059. The rate may not cover direct rent or food costs.

(h) The county shall negotiate individual rates with vendors and may be reimbursed for actual costs up to the greater of the county's current approved rate or 60 percent of the maximum rate in fiscal year 1994 and 65 percent of the maximum rate in fiscal year 1995 for each service within each program.

(i) On July 1, 1993, the commissioner shall increase the maximum rate for home–delivered meals to $4.50 per meal.

(j) Reimbursement for the medical assistance recipients under the approved waiver shall be made from the medical assistance account through the invoice processing procedures of the department's Medicaid Management Information System (MMIS), only with the approval of the client's case manager. The budget for the state share of the Medicaid expenditures shall be forecasted with the medical assistance budget, and shall be consistent with the approved waiver.

(k) Beginning July 1, 1991, the state shall reimburse counties according to the payment schedule in section 256.025 for the county share of costs incurred under this subdivision on or after January 1, 1991, for individuals who are receiving medical assistance.

Subd. 3a. **Reimbursement rate; Anoka county.** Notwithstanding subdivision 3, paragraph (h), or any other law to the contrary, for services rendered on or after January 1, 1996, Anoka county may pay vendors, and the commissioner shall reimburse the county, for actual costs up to a limit which is the maximum rate in effect on December 31, 1995, plus half the difference between that rate and the maximum allowed state rate for home health aide and homemaker services.

[For text of subd 4, see M.S.1994]

Subd. 5. **Reassessments for waiver clients.** A reassessment of a client served under the elderly or disabled waiver must be conducted at least every 12 months and at other times when the case manager determines that there has been significant change in the client's functioning. This may include instances where the client is discharged from the hospital.

Subd. 6. **Implementation of care plan.** If the county administering waivered services is different than the county of financial responsibility, the care plan may be implemented without the approval of the county of financial responsibility.

History: *1995 c 207 art 6 s 70–74; 1995 c 263 s 9*

256B.092 CASE MANAGEMENT OF PERSONS WITH MENTAL RETARDATION OR RELATED CONDITIONS.

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

Subd. 4. **Home and community–based services for persons with mental retardation or related conditions.** (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 mental retardation or related conditions 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 mental retardation or related conditions and subsequent amendments.

(b) Effective July 1, 1995, contingent upon federal approval and state appropriations made available for this purpose, and in conjunction with Laws 1995, chapter 207, article 8, section 40, the commissioner of human services shall allocate resources to county agencies for home and community–based waivered services for persons with mental retardation or related conditions authorized but not receiving those services as of June 30, 1995, based upon the average resource need of persons with similar functional characteristics. To ensure service continuity for service recipients receiving home and community–based waivered services for persons with mental retardation or related conditions prior to July 1, 1995, the commissioner shall make available to the county of financial responsibility home and community–based waivered services resources based upon fiscal year 1995 authorized levels.

(c) Home and community–based resources for all recipients shall be managed by the county of financial responsibility within an allowable reimbursement average established for each county. Payments for home and community–based services provided to individual recipients shall not exceed amounts authorized by the county of financial responsibility. For specifically identified former residents of nursing facilities, the commissioner shall be responsible for authorizing payments and payment limits under the appropriate home and community–based service program. Payment is available under this subdivision only for persons who, if not provided these services, would require the level of care provided in an intermediate care facility for persons with mental retardation or related conditions.

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

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 mental retardation or related conditions, 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 mental retardation or related conditions;

(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.

[For text of subds 5 to 10, see M.S.1994]

History: *1995 c 207 art 3 s 19; art 8 s 34*

256B.0925 [Repealed, 1995 c 186 s 51]

256B.093 SERVICES FOR PERSONS WITH TRAUMATIC BRAIN INJURIES.

Subdivision 1. **State traumatic brain injury program.** The commissioner of human services shall:

(1) maintain a statewide traumatic brain injury program;

(2) supervise and coordinate services and policies for persons with traumatic brain injuries;

(3) contract with qualified agencies or employ staff to provide statewide administrative case management and consultation;

(4) maintain an advisory committee to provide recommendations in reports to the commissioner regarding program and service needs of persons with traumatic brain injuries. The advisory committee shall consist of no less 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;

(5) investigate the need for the development of rules or statutes for the traumatic 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.

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 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 traumatic brain injury home and community-based waiver;

(3) approving traumatic brain injury waiver eligibility or care plans or both;

(4) 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;

(5) providing technical assistance to promote statewide development of appropriate, accessible, and cost-effective medical assistance services and related policy;

(6) providing training and outreach to facilitate access to appropriate home and community-based services to prevent institutionalization;

(7) facilitating appropriate admissions, continued stay review, discharges, and utilization review for neurobehavioral hospitals and other specialized institutions;

(8) providing technical assistance on the use of prior authorization of home care services and coordination of these services with other medical assistance services;

(9) 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

(10) 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 (b), clause (5), 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.

[For text of subd 4, see M.S.1994]

History: *1995 c 207 art 6 s 75–78*

256B.15 CLAIMS AGAINST ESTATES.

[For text of subd 1, see M.S.1994]

Subd. 1a. **Estates subject to claims.** If a person receives any medical assistance hereunder, on the person's death, if single, or on the death of the survivor of a married couple, either or both of whom received medical assistance, the total amount paid for medical assistance rendered for the person and spouse shall be filed as a claim against the estate of the person or the estate of the surviving spouse in the court having jurisdiction to probate the estate.

A claim shall be filed if medical assistance was rendered for either or both persons under one of the following circumstances:

(a) the person was over 55 years of age, and received services under this chapter, excluding alternative care;

(b) the person resided in a medical institution for six months or longer, received services under this chapter excluding alternative care, and, at the time of institutionalization or application for medical assistance, whichever is later, the person could not have reasonably been expected to be discharged and returned home, as certified in writing by the person's treating physician. For purposes of this section only, a "medical institution" means a skilled nursing facility, intermediate care facility, intermediate care facility for persons with mental retardation, nursing facility, or inpatient hospital; or

(c) the person received general assistance medical care services under chapter 256D.

The claim shall be considered an expense of the last illness of the decedent for the purpose of section 524.3–805. 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 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.

Subd. 2. **Limitations on claims.** The claim shall include only the total amount of medical assistance rendered after age 55 or during a period of institutionalization described in subdivision 1a, clause (b), and the total amount of general assistance medical care rendered, and shall not include interest. Claims that have been allowed but not paid shall bear interest according to section 524.3–806, paragraph (d). A claim against the estate of a surviving spouse who did not receive medical assistance, for medical assistance rendered for the predeceased spouse, 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.

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

Subd. 5. **Undue hardship.** 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.

History: *1995 c 207 art 6 s 79–81*

NOTE: The amendments to subdivisions 1a and 2 by Laws 1995, chapter 207, article 6, sections 79 and 80, relating only to the age of a medical assistance recipient for purposes of estate claims, are effective for persons who are between the ages of 55 and 64 on or after July 1, 1995, for the total amount of assistance on or after July 1, 1995. See Laws 1995, chapter 207, article 6, section 125, subdivision 1.

256B.19 DIVISION OF COST.

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

Subd. 1b. **Portion of nonfederal share to be paid by government hospitals.** (a) In addition to the percentage contribution paid by a county under subdivision 1, the governmental units designated in this subdivision shall be responsible for an additional portion of the nonfederal share of medical assistance costs attributable to them. For purposes of this subdivision, "designated governmental unit" means Hennepin county and the University of Minnesota. For purposes of this subdivision, "public hospital" means the Hennepin County Medical Center and the University of Minnesota hospital.

(b) From July 1, 1993 through June 30, 1994, Hennepin county shall on a monthly basis transfer an amount equal to 1.8 percent of the public hospital's net patient revenues, excluding net Medicare revenue to the state Medicaid agency.

(c) Effective July 1, 1994, each of the governmental units designated in paragraph (a) shall on a monthly basis transfer an amount equal to 1.8 percent of the public hospital's net patient revenues, excluding net Medicare revenue, to the state Medicaid agency. The base year for determining this transfer amount shall be established according to section 256.9657, subdivision 4.

(d) These sums shall be part of the designated governmental unit's portion of the nonfederal share of medical assistance costs, but shall not be subject to payback provisions of section 256.025.

Subd. 1c. **Additional portion of nonfederal share.** In addition to any payment required under subdivision 1b, Hennepin county shall be responsible for a monthly transfer payment of $1,500,000, due before noon on the 15th of each month and the University of Minnesota shall be responsible for a monthly transfer payment of $500,000 due before noon on the 15th of each month, beginning July 15, 1995. These sums shall be part of the designated governmental unit's portion of the nonfederal share of medical assistance costs, but shall not be subject to payback provisions of section 256.025.

Subd. 1d. **Portion of nonfederal share to be paid by certain counties.** In addition to the percentage contribution paid by a county under subdivision 1, the governmental units designated in this subdivision shall be responsible for an additional portion of the nonfederal share of medical assistance cost. For purposes of this subdivision, "designated governmental unit" means the counties of Becker, Beltrami, Clearwater, Cook, Dodge, Hubbard, Itasca, Lake, Pennington, Pipestone, Ramsey, St. Louis, Steele, Todd, Traverse, and Wadena.

Beginning in 1994, each of the governmental units designated in this subdivision shall transfer before noon on May 31 to the state Medicaid agency an amount equal to the number of licensed beds in any nursing home owned and operated by the county, with the county named as licensee, multiplied by $5,723. If two or more counties own and operate a nursing home, the payment shall be prorated. These sums shall be part of the designated governmental unit's portion of the nonfederal share of medical assistance costs, but shall not be subject to payback provisions of section 256.025.

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

Subd. 2c. **Obligation of local agency to investigate and determine eligibility for medical assistance.** (a) When the commissioner receives information that indicates that a general assistance medical care recipient or MinnesotaCare program enrollee may be eligible for medical assistance, the commissioner may notify the appropriate local agency of that fact. The local agency must investigate eligibility for medical assistance and take appropriate

action and notify the commissioner of that action within 90 days from the date notice is issued. If the person is eligible for medical assistance, the local agency must find eligibility retroactively to the date on which the person met all eligibility requirements.

(b) When a prepaid health plan under a contract with the state to provide medical assistance services notifies the commissioner that an infant has been or will be born to an enrollee under the contract, the commissioner may notify the appropriate local agency of that fact. The local agency must investigate eligibility for medical assistance for the infant, take appropriate action, and notify the commissioner of that action within 90 days from the date notice is issued. If the infant would have been eligible on the date of birth, the local agency must establish eligibility retroactively to that month.

(c) For general assistance medical care recipients and MinnesotaCare program enrollees, if the local agency fails to comply with paragraph (a), the local agency is responsible for the entire cost of general assistance medical care or MinnesotaCare program services provided from the date the commissioner issues the notice until the date the local agency takes appropriate action on the case and notifies the commissioner of the action. For infants, if the local agency fails to comply with paragraph (b), the commissioner may determine eligibility for medical assistance for the infant for a period of two months, and the local agency shall be responsible for the entire cost of medical assistance services provided for that infant, in addition 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.

[For text of subd 3, see M.S.1994]

History: *1995 c 207 art 6 s 82–84; 1995 c 234 art 8 s 56*

256B.27 MEDICAL ASSISTANCE; COST REPORTS.

[For text of subds 1 and 2, see M.S.1994]

Subd. 2a. Each year the commissioner shall provide for the on–site audit of the cost reports of nursing homes participating as vendors of medical assistance. The commissioner shall select for audit at least 15 percent of these nursing homes at random or using factors including, but not limited to: change in ownership; frequent changes in administration in excess of normal turnover rates; complaints to the commissioner of health about care, safety, or rights; where previous inspections or reinspections under section 144A.10 have resulted in correction orders related to care, safety, or rights; or where persons involved in ownership or administration of the facility have been indicted for alleged criminal activity.

[For text of subds 3 to 5, see M.S.1994]

History: *1995 c 207 art 11 s 6*

256B.431 RATE DETERMINATION.

[For text of subds 1 to 2a, see M.S.1994]

Subd. 2b. **Operating costs, after July 1, 1985.** (a) For rate years beginning on or after July 1, 1985, the commissioner shall establish procedures for determining per diem reimbursement for operating costs.

(b) The commissioner shall contract with an econometric firm with recognized expertise in and access to national economic change indices that can be applied to the appropriate cost categories when determining the operating cost payment rate.

(c) The commissioner shall analyze and evaluate each nursing facility's cost report of allowable operating costs incurred by the nursing facility during the reporting year immediately preceding the rate year for which the payment rate becomes effective.

(d) The commissioner shall establish limits on actual allowable historical operating cost per diems based on cost reports of allowable operating costs for the reporting year that begins October 1, 1983, taking into consideration relevant factors including resident needs, geographic location, size of the nursing facility, and the costs that must be incurred for the care of

residents in an efficiently and economically operated nursing facility. In developing the geographic groups for purposes of reimbursement under this section, the commissioner shall ensure that nursing facilities in any county contiguous to the Minneapolis–St. Paul seven–county metropolitan area are included in the same geographic group. The limits established by the commissioner shall not be less, in the aggregate, than the 60th percentile of total actual allowable historical operating cost per diems for each group of nursing facilities established under subdivision 1 based on cost reports of allowable operating costs in the previous reporting year. For rate years beginning on or after July 1, 1989, facilities located in geographic group I as described in Minnesota Rules, part 9549.0052, on January 1, 1989, may choose to have the commissioner apply either the care related limits or the other operating cost limits calculated for facilities located in geographic group II, or both, if either of the limits calculated for the group II facilities is higher. The efficiency incentive for geographic group I nursing facilities must be calculated based on geographic group I limits. The phase–in must be established utilizing the chosen limits. For purposes of these exceptions to the geographic grouping requirements, the definitions in Minnesota Rules, parts 9549.0050 to 9549.0059 (Emergency), and 9549.0010 to 9549.0080, apply. The limits established under this paragraph remain in effect until the commissioner establishes a new base period. Until the new base period is established, the commissioner shall adjust the limits annually using the appropriate economic change indices established in paragraph (e). In determining allowable historical operating cost per diems for purposes of setting limits and nursing facility payment rates, the commissioner shall divide the allowable historical operating costs by the actual number of resident days, except that where a nursing facility is occupied at less than 90 percent of licensed capacity days, the commissioner may establish procedures to adjust the computation of the per diem to an imputed occupancy level at or below 90 percent. The commissioner shall establish efficiency incentives as appropriate. The commissioner may establish efficiency incentives for different operating cost categories. The commissioner shall consider establishing efficiency incentives in care related cost categories. The commissioner may combine one or more operating cost categories and may use different methods for calculating payment rates for each operating cost category or combination of operating cost categories. For the rate year beginning on July 1, 1985, the commissioner shall:

(1) allow nursing facilities that have an average length of stay of 180 days or less in their skilled nursing level of care, 125 percent of the care related limit and 105 percent of the other operating cost limit established by rule; and

(2) exempt nursing facilities licensed on July 1, 1983, by the commissioner to provide residential services for the physically handicapped under Minnesota Rules, parts 9570.2000 to 9570.3600, from the care related limits and allow 105 percent of the other operating cost limit established by rule.

For the purpose of calculating the other operating cost efficiency incentive for nursing facilities referred to in clause (1) or (2), the commissioner shall use the other operating cost limit established by rule before application of the 105 percent.

(e) The commissioner shall establish a composite index or indices by determining the appropriate economic change indicators to be applied to specific operating cost categories or combination of operating cost categories.

(f) Each nursing facility shall receive an operating cost payment rate equal to the sum of the nursing facility's operating cost payment rates for each operating cost category. The operating cost payment rate for an operating cost category shall be the lesser of the nursing facility's historical operating cost in the category increased by the appropriate index established in paragraph (e) for the operating cost category plus an efficiency incentive established pursuant to paragraph (d) or the limit for the operating cost category increased by the same index. If a nursing facility's actual historic operating costs are greater than the prospective payment rate for that rate year, there shall be no retroactive cost settle–up. In establishing payment rates for one or more operating cost categories, the commissioner may establish separate rates for different classes of residents based on their relative care needs.

(g) The commissioner shall include the reported actual real estate tax liability or payments in lieu of real estate tax of each nursing facility as an operating cost of that nursing facility. Allowable costs under this subdivision for payments made by a nonprofit nursing facility that are in lieu of real estate taxes shall not exceed the amount which the nursing facil-

ity would have paid to a city or township and county for fire, police, sanitation services, and road maintenance costs had real estate taxes been levied on that property for those purposes. For rate years beginning on or after July 1, 1987, the reported actual real estate tax liability or payments in lieu of real estate tax of nursing facilities shall be adjusted to include an amount equal to one–half of the dollar change in real estate taxes from the prior year. The commissioner shall include a reported actual special assessment, and reported actual license fees required by the Minnesota department of health, for each nursing facility as an operating cost of that nursing facility. For rate years beginning on or after July 1, 1989, the commissioner shall include a nursing facility's reported public employee retirement act contribution for the reporting year as apportioned to the care–related operating cost categories and other operating cost categories multiplied by the appropriate composite index or indices established pursuant to paragraph (e) as costs under this paragraph. Total adjusted real estate tax liability, payments in lieu of real estate tax, actual special assessments paid, the indexed public employee retirement act contribution, and license fees paid as required by the Minnesota department of health, for each nursing facility (1) shall be divided by actual resident days in order to compute the operating cost payment rate for this operating cost category, (2) shall not be used to compute the care–related operating cost limits or other operating cost limits established by the commissioner, and (3) shall not be increased by the composite index or indices established pursuant to paragraph (e), unless otherwise indicated in this paragraph.

(h) For rate years beginning on or after July 1, 1987, the commissioner shall adjust the rates of a nursing facility that meets the criteria for the special dietary needs of its residents and the requirements in section 31.651. The adjustment for raw food cost shall be the difference between the nursing facility's allowable historical raw food cost per diem and 115 percent of the median historical allowable raw food cost per diem of the corresponding geographic group.

The rate adjustment shall be reduced by the applicable phase–in percentage as provided under subdivision 2h.

(i) For the cost report year ending September 30, 1996, and for all subsequent reporting years, certified nursing facilities must identify, differentiate, and record resident day statistics for residents in case mix classification A who, on or after July 1, 1996, meet the modified level of care criteria in section 144.0721. The resident day statistics shall be separated into case mix classification A–1 for any resident day meeting the high–function class A level of care criteria and case mix classification A–2 for other case mix class A resident days.

[For text of subds 2c to 2i, see M.S.1994]

Subd. 2j. **Hospital–attached nursing facility status.** (a) For the purpose of setting rates under Minnesota Rules, parts 9549.0010 to 9549.0080, for rate years beginning after June 30, 1989, a hospital–attached nursing facility means a nursing facility which meets the requirements of clauses (1) to (3):

(1) the nursing facility is recognized by the federal Medicare program to be a hospital–based nursing facility for purposes of being subject to higher cost limits accorded hospital–based nursing facilities under the Medicare program, or, prior to June 30, 1983, was classified as a hospital–attached nursing facility under Minnesota Rules, parts 9510.0010 to 9510.0480;

(2) the nursing facility's cost report filed under Minnesota Rules, parts 9549.0010 to 9549.0080, shall use the same cost allocation principles and methods used in the reports filed for the Medicare program except as provided in clause (3); and

(3) direct identification of costs to the nursing facility cost center will be permitted only when the comparable hospital costs have also been directly identified to a cost center which is not allocated to the nursing facility.

(b) For rate years beginning after June 30, 1989, a nursing facility and hospital, which have applied for hospital–based nursing facility status under the federal Medicare program during the reporting year or the nine–month period following the nursing facility's reporting year, shall be considered a hospital–attached nursing facility for purposes of setting payment rates under Minnesota Rules, parts 9549.0010 to 9549.0080, for the rate year following the reporting year or the nine–month period in which the facility made its Medicare application. The nursing facility must file its cost report or an amended cost report for that reporting year

before the following rate year using Medicare principles and Medicare's recommended cost allocation methods had the Medicare program's hospital–based nursing facility status been granted to the nursing facility. For each subsequent rate year, the nursing facility must meet the definition requirements in paragraph (a). If the nursing facility is denied hospital–based nursing facility status under the Medicare program, the nursing facility's payment rates for the rate years the nursing facility was considered to be a hospital–attached nursing facility pursuant to this paragraph shall be recalculated treating the nursing facility as a non–hospital–attached nursing facility.

(c) For rate years beginning on or after July 1, 1995, a nursing facility shall be considered a hospital attached nursing facility for purposes of setting payment rates under Minnesota Rules, parts 9549.0010 to 9549.0080 and this section if it meets the requirements of paragraphs (a) and (b), and

(1) the hospital and nursing facility are physically attached or connected by a tunnel or skyway; or

(2) the nursing facility was recognized by the Medicare program as hospital attached as of January 1, 1995, and this status has been maintained continuously.

[For text of subds 2k to 14, see M.S.1994]

Subd. 15. **Capital repair and replacement cost reporting and rate calculation.** For rate years beginning after June 30, 1993, a nursing facility's capital repair and replacement payment rate shall be established annually as provided in paragraphs (a) to (e).

(a) Notwithstanding Minnesota Rules, part 9549.0060, subpart 12, the costs of any of the following items not included in the equity incentive computations under subdivision 16 or reported as a capital asset addition under subdivision 18, paragraph (b), including cash payment for equity investment and principal and interest expense for debt financing, must be reported in the capital repair and replacement cost category:

(1) wall coverings;

(2) paint;

(3) floor coverings;

(4) window coverings;

(5) roof repair; and

(6) window repair or replacement.

(b) Notwithstanding Minnesota Rules, part 9549.0060, subpart 12, the repair or replacement of a capital asset not included in the equity incentive computations under subdivision 16 or reported as a capital asset addition under subdivision 18, paragraph (b), must be reported under this subdivision when the cost of the item exceeds $500, or in the plant operations and maintenance cost category when the cost of the item is equal to or less than $500.

(c) To compute the capital repair and replacement payment rate, the allowable annual repair and replacement costs for the reporting year must be divided by actual resident days for the reporting year. The annual allowable capital repair and replacement costs shall not exceed $150 per licensed bed. The excess of the allowed capital repair and replacement costs over the capital repair and replacement limit shall be a cost carryover to succeeding cost reporting periods, except that sale of a facility, under subdivision 14, shall terminate the carryover of all costs except those incurred in the most recent cost reporting year. The termination of the carryover shall have effect on the capital repair and replacement rate on the same date as provided in subdivision 14, paragraph (f), for the sale. For rate years beginning after June 30, 1994, the capital repair and replacement limit shall be subject to the index provided in subdivision 3f, paragraph (a). For purposes of this subdivision, the number of licensed beds shall be the number used to calculate the nursing facility's capacity days. The capital repair and replacement rate must be added to the nursing facility's total payment rate.

(d) Capital repair and replacement costs under this subdivision shall not be counted as either care–related or other operating costs, nor subject to care–related or other operating limits.

(e) If costs otherwise allowable under this subdivision are incurred as the result of a project approved under the moratorium exception process in section 144A.073, or in connec-

tion with an addition to or replacement of buildings, attached fixtures, or land improvements for which the total historical cost of these assets exceeds the lesser of $150,000 or ten percent of the nursing facility's appraised value, these costs must be claimed under subdivision 16 or 17, as appropriate.

[For text of subd 16, see M.S.1994]

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

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

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

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

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

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

(d) The incremental increase in a nursing facility's rental rate, determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section, resulting from the acquisition of allowable capital assets, and allowable debt and interest expense under this subdivision shall be added to its property-related payment rate and shall be effective on the first day of the month following the month in which the moratorium project was completed.

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

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

(g) For purposes of this paragraph, a total replacement means the complete replacement of the nursing facility's physical plant through the construction of a new physical plant or the transfer of the nursing facility's license from one physical plant location to another. For total

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

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

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

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

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

[For text of subds 18 to 22, see M.S.1994]

Subd. 23. **County nursing home payment adjustments.** (a) Beginning in 1994, the commissioner shall pay a nursing home payment adjustment on May 31 after noon to a county in which is located a nursing home that, as of January 1 of the previous year, was county–owned and operated, with the county named as licensee by the commissioner of health, and had over 40 beds and medical assistance occupancy in excess of 50 percent during the reporting year ending September 30, 1991. The adjustment shall be an amount equal to $16 per calendar day multiplied by the number of beds licensed in the facility as of September 30, 1991.

(b) Payments under paragraph (a) are excluded from medical assistance per diem rate calculations. These payments are required notwithstanding any rule prohibiting medical assistance payments from exceeding payments from private pay residents. A facility receiving a payment under paragraph (a) may not increase charges to private pay residents by an amount equivalent to the per diem amount payments under paragraph (a) would equal if converted to a per diem.

[For text of subd 24, see M.S.1994]

Subd. 25. **Changes to nursing facility reimbursement beginning July 1, 1995.** The nursing facility reimbursement changes in paragraphs (a) to (g) shall apply in the sequence specified to Minnesota Rules, parts 9549.0010 to 9549.0080, and this section, beginning July 1, 1995.

(a) The eight–cent adjustment to care–related rates in subdivision 22, paragraph (e), shall no longer apply.

(b) For rate years beginning on or after July 1, 1995, the commissioner shall limit a nursing facility's allowable operating per diem for each case mix category for each rate year as in clauses (1) to (3).

(1) For the rate year beginning July 1, 1995, the commissioner shall group nursing facilities into two groups, freestanding and nonfreestanding, within each geographic group, us-

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

(i) is at or below the median minus 1.0 standard deviation of the array, the commissioner shall limit the nursing facility's allowable operating cost per diem for each case mix category to the lesser of the prior reporting year's allowable operating cost per diems plus the inflation factor as established in paragraph (f), clause (2), increased by six percentage points, or the current reporting year's corresponding allowable operating cost per diem;

(ii) is between minus .5 standard deviation and minus 1.0 standard deviation below the median of the array, the commissioner shall limit the nursing facility's allowable operating cost per diem for each case mix category to the lesser of the prior reporting year's allowable operating cost per diems plus the inflation factor as established in paragraph (f), clause (2), increased by four percentage points, or the current reporting year's corresponding allowable operating cost per diem; or

(iii) is equal to or above minus .5 standard deviation below the median of the array, the commissioner shall limit the nursing facility's allowable operating cost per diem for each case mix category to the lesser of the prior reporting year's allowable operating cost per diems plus the inflation factor as established in paragraph (f), clause (2), increased by three percentage points, or the current reporting year's corresponding allowable operating cost per diem.

(2) For the rate year beginning on July 1, 1996, the commissioner shall limit the nursing facility's allowable operating cost per diem for each case mix category to the lesser of the prior reporting year's allowable operating cost per diems plus the inflation factor as established in paragraph (f), clause (2), increased by one percentage point or the current reporting year's corresponding allowable operating cost per diems; and

(3) For rate years beginning on or after July 1, 1997, the commissioner shall limit the nursing facility's allowable operating cost per diem for each case mix category to the lesser of the reporting year prior to the current reporting year's allowable operating cost per diems plus the inflation factor as established in paragraph (f), clause (2), or the current reporting year's corresponding allowable operating cost per diems.

(c) For rate years beginning on July 1, 1995, the commissioner shall limit the allowable operating cost per diems for high cost nursing facilities. After application of the limits in paragraph (b) to each nursing facility's operating cost per diems, the commissioner shall group nursing facilities into two groups, freestanding or nonfreestanding, within each geographic group. A nonfreestanding nursing facility is a nursing facility whose other operating cost per diems are subject to hospital attached, short length of stay, or rule 80 limits. All other nursing facilities shall be considered freestanding nursing facilities. The commissioner shall then array all nursing facilities within each grouping by their allowable case mix A operating cost per diems. In calculating a nursing facility's operating cost per diem for this purpose, the commissioner shall exclude the raw food cost per diem related to providing special diets that are based on religious beliefs, as determined in subdivision 2b, paragraph (h). For those nursing facilities in each grouping whose case mix A operating cost per diem exceeds 1.0 standard deviation above the median, the commissioner shall reduce their allowable operating cost per diems by two percent. For those nursing facilities in each grouping whose case mix A operating cost per diem exceeds 0.5 standard deviation above the median but is less than or equal to 1.0 standard deviation above the median, the commissioner shall reduce their allowable operating cost per diems by one percent.

(d) For rate years beginning on or after July 1, 1996, the commissioner shall limit the allowable operating cost per diems for high cost nursing facilities. After application of the limits in paragraph (b) to each nursing facility's operating cost per diems, the commissioner shall group nursing facilities into two groups, freestanding or nonfreestanding, within each

geographic group. A nonfreestanding nursing facility is a nursing facility whose other operating cost per diems are subject to hospital attached, short length of stay, or rule 80 limits. All other nursing facilities shall be considered freestanding nursing facilities. The commissioner shall then array all nursing facilities within each grouping by their allowable case mix A operating cost per diems. In calculating a nursing facility's operating cost per diem for this purpose, the commissioner shall exclude the raw food cost per diem related to providing special diets that are based on religious beliefs, as determined in subdivision 2b, paragraph (h). In those nursing facilities in each grouping whose case mix A operating cost per diem exceeds 1.0 standard deviation above the median, the commissioner shall reduce their allowable operating cost per diems by three percent. For those nursing facilities in each grouping whose case mix A operating cost per diem exceeds 0.5 standard deviation above the median but is less than or equal to 1.0 standard deviation above the median, the commissioner shall reduce their allowable operating cost per diems by two percent.

(e) For rate years beginning on or after July 1, 1995, the commissioner shall determine a nursing facility's efficiency incentive by first computing the allowable difference, which is the lesser of $4.50 or the amount by which the facility's other operating cost limit exceeds its nonadjusted other operating cost per diem for that rate year. The commissioner shall compute the efficiency incentive by:

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

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

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

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

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

(f) For rate years beginning on or after July 1, 1995, the forecasted price index for a nursing facility's allowable operating cost per diems shall be determined under clauses (1) to (3) using the change in the Consumer Price Index–All Items (United States city average) (CPI–U) or the change in the Nursing Home Market Basket, both as forecasted by Data Resources Inc., whichever is applicable. The commissioner shall use the indices as forecasted in the fourth quarter of the calendar year preceding the rate year, subject to subdivision 21, paragraph (c). If, as a result of federal legislative or administrative action, the methodology used to calculate the Consumer Price Index–All Items (United States city average) (CPI–U) changes, the commissioner shall develop a conversion factor or other methodology to convert the CPI–U index factor that results from the new methodology to an index factor that approximates, as closely as possible, the index factor that would have resulted from application of the original CPI–U methodology prior to any changes in methodology. The commissioner shall use the conversion factor or other methodology to calculate an adjusted inflation index. The adjusted inflation index must be used to calculate payment rates under this section instead of the CPI–U index specified in paragraph (d). If the commissioner is required to develop an adjusted inflation index, the commissioner shall report to the legislature as part of the next budget submission the fiscal impact of applying this index.

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

(2) The Nursing Home Market Basket forecasted index for allowable operating costs and per diem limits shall be based on the 12–month period between the midpoints of the two reporting years preceding the rate year.

(3) For rate years beginning on or after July 1, 1996, the forecasted index for operating cost limits referred to in subdivision 21, paragraph (b), shall be based on the CPI–U for the 12–month period between the midpoints of the two reporting years preceding the rate year.

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

History: *1995 c 207 art 6 s 85,86; art 7 s 23–26*

256B.432 LONG-TERM CARE FACILITIES; CENTRAL, AFFILIATED, OR CORPORATE OFFICE COSTS.

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

(a) "Management agreement" means an agreement in which one or more of the following criteria exist:

(1) the central, affiliated, or corporate office has or is authorized to assume day-to-day operational control of the nursing facility for any six-month period within a 24-month period. "Day-to-day operational control" means that the central, affiliated, or corporate office has the authority to require, mandate, direct, or compel the employees of the nursing facility to perform or refrain from performing certain acts, or to supplant or take the place of the top management of the nursing facility. "Day-to-day operational control" includes the authority to hire or terminate employees or to provide an employee of the central, affiliated, or corporate office to serve as administrator of the nursing facility;

(2) the central, affiliated, or corporate office performs or is authorized to perform two or more of the following: the execution of contracts; authorization of purchase orders; signature authority for checks, notes, or other financial instruments; requiring the nursing facility to use the group or volume purchasing services of the central, affiliated, or corporate office; or the authority to make annual capital expenditures for the nursing facility exceeding $50,000, or $500 per licensed bed, whichever is less, without first securing the approval of the nursing facility board of directors;

(3) the central, affiliated, or corporate office becomes or is required to become the licensee under applicable state law;

(4) the agreement provides that the compensation for services provided under the agreement is directly related to any profits made by the nursing facility; or

(5) the nursing facility entering into the agreement is governed by a governing body that meets fewer than four times a year, that does not publish notice of its meetings, or that does not keep formal records of its proceedings.

(b) "Consulting agreement" means any agreement the purpose of which is for a central, affiliated, or corporate office to advise, counsel, recommend, or suggest to the owner or operator of the nonrelated nursing facility measures and methods for improving the operations of the nursing facility.

(c) "Nursing facility" means a nursing facility whose medical assistance rates are determined according to section 256B.431.

Subd. 2. **Effective date.** For rate years beginning on or after July 1, 1990, the central, affiliated, or corporate office cost allocations in subdivisions 3 to 6 must be used when determining medical assistance rates under sections 256B.431 and 256B.50.

Subd. 3. **Allocation; direct identification of costs of nursing facilities; management agreement.** All costs that can be directly identified with a specific nursing facility that is a related organization to the central, affiliated, or corporate office, or that is controlled by the central, affiliated, or corporate office under a management agreement, must be allocated to that nursing facility.

[For text of subd 4, see M.S.1994]

Subd. 5. **Allocation of remaining costs; allocation ratio.** (a) After the costs that can be directly identified according to subdivisions 3 and 4 have been allocated, the remaining central, affiliated, or corporate office costs must be allocated between the nursing facility operations and the other activities or facilities unrelated to the nursing facility operations based on the ratio of total operating costs.

(b) For purposes of allocating these remaining central, affiliated, or corporate office costs, the numerator for the allocation ratio shall be determined as follows:

(1) for nursing facilities that are related organizations or are controlled by a central, affiliated, or corporate office under a management agreement, the numerator of the allocation ratio shall be equal to the sum of the total operating costs incurred by each related organization or controlled nursing facility;

(2) for a central, affiliated, or corporate office providing goods or services to related organizations that are not nursing facilities, the numerator of the allocation ratio shall be equal to the sum of the total operating costs incurred by the nonnursing facility related organizations;

(3) for a central, affiliated, or corporate office providing goods or services to unrelated nursing facilities under a consulting agreement, the numerator of the allocation ratio shall be equal to the greater of directly identified central, affiliated, or corporate costs or the contracted amount; or

(4) for business activities that involve the providing of goods or services to unrelated parties which are not nursing facilities, the numerator of the allocation ratio shall be equal to the greater of directly identified costs or revenues generated by the activity or function.

(c) The denominator for the allocation ratio is the sum of the numerators in paragraph (b), clauses (1) to (4).

Subd. 6. **Cost allocation between nursing facilities.** (a) Those nursing operations that have nursing facilities both in Minnesota and comparable facilities outside of Minnesota must allocate the nursing operation's central, affiliated, or corporate office costs identified in subdivision 5 to Minnesota based on the ratio of total resident days in Minnesota nursing facilities to the total resident days in all facilities.

(b) The Minnesota nursing operation's central, affiliated, or corporate office costs identified in paragraph (a) must be allocated to each Minnesota nursing facility on the basis of resident days.

[For text of subds 7 and 8, see M.S.1994]

History: *1995 c 207 art 7 s 27–31*

NOTE: The amendments to subdivisions 1, 2, 3, 5, and 6, by Laws 1995, chapter 207, article 7, sections 27 to 31, are effective for ICF/MR rate years beginning after September 30, 1996. See Laws 1995, chapter 207, article 7, section 44, subdivision 3.

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

Subdivision 1. **Alternative payment demonstration project established.** The commissioner of human services shall establish a contractual alternative payment demonstration project for paying for nursing facility services under the medical assistance program. A nursing facility may apply to be paid under the contractual alternative payment demonstration project instead of the cost–based payment system established under section 256B.431. A nursing facility electing to use the alternative payment demonstration project must enter into a contract with the commissioner. Payment rates and procedures for facilities electing to use the alternative payment demonstration project are determined and governed by this section and by the terms of the contract. The commissioner may negotiate different contract terms for different nursing facilities.

Subd. 2. **Requests for proposals.** (a) No later than August 1, 1995, the commissioner shall publish in the State Register a request for proposals to provide nursing facility services according to this section. The commissioner shall issue two additional requests for proposals prior to July 1, 1997, based upon a timetable established by the commissioner. The commissioner must respond to all proposals in a timely manner.

(b) The commissioner may reject any proposal if, in the judgment of the commissioner, a contract with a particular facility is not in the best interests of the residents of the facility or the state of Minnesota. The commissioner may accept up to the number of proposals that can be adequately supported with available state resources, as determined by the commissioner, except that the commissioner shall not contract with more than 40 nursing facilities as part of any request for proposals. The commissioner may accept proposals from a single nursing facility or from a group of facilities through a managing entity. The commissioner shall seek to ensure that nursing facilities under contract are located in all geographic areas of the state. The commissioner shall present recommendations to the legislature by February 1, 1996, on the number of nursing facility contracts that may be entered into by the commissioner as a result of a request for proposals.

(c) In issuing the request for proposals, the commissioner may develop reasonable requirements which, in the judgment of the commissioner, are necessary to protect residents or

ensure that the contractual alternative payment demonstration project furthers the interest of the state of Minnesota. The request for proposals may include, but need not be limited to, the following:

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

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

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

(4) a requirement to agree to participate in a project to develop data collection systems and outcome–based standards for managed care contracting for long–term care services. Among other requirements specified by the commissioner, each facility entering into a contract may be required to pay an annual fee in an amount determined by the commissioner not to exceed $50 per bed. Revenue generated from the fees is appropriated to the commissioner and must be used to contract with a qualified consultant or contractor to develop data collection systems and outcome–based contracting standards;

(5) a requirement that contractors agree to maintain Medicare cost reports and to submit them to the commissioner upon request or at times specified by the commissioner;

(6) a requirement for demonstrated willingness and ability to develop and maintain data collection and retrieval systems to be used in measuring outcomes; and

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

(d) In addition to the information and assurances contained in the submitted proposals, the commissioner may consider the following in determining whether to accept or deny a proposal:

(1) the facility's history of compliance with federal and state laws and rules;

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

(3) financial history and solvency; and

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

(e) If the commissioner rejects the proposal of a nursing facility, the commissioner shall provide written notice to the facility of the reason for the rejection, including the factors and evidence upon which the rejection was based.

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

(b) All contracts entered into under this section are for a term of four years. Either party may terminate a contract effective July 1 of any year by providing written notice to the other party no later than April 1 of that year. If neither party provides written notice of termination by April 1, the contract is automatically renewed for the next rate year. The parties may voluntarily renegotiate the terms of the contract at any time by mutual agreement.

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

Subd. 4. **Alternate rates for nursing facilities.** (a) For nursing facilities which have their payment rates determined under this section rather than section 256B.431, subdivision

25, the commissioner shall establish a rate under this subdivision. The nursing facility must enter into a written contract with the commissioner.

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

(c) A nursing facility's case mix payment rates for the second and subsequent years of a facility's contract under this section are the previous rate year's contract payment rates plus an inflation adjustment. The index for the inflation adjustment must be based on the change in the Consumer Price Index–All Items (United States City average) (CPI–U) forecasted by Data Resources, Inc., as forecasted in the fourth quarter of the calendar year preceding the rate year. The inflation adjustment must be based on the 12–month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined.

(d) The commissioner may develop additional incentive–based payments of up to five percent above the standard contract rate for achieving outcomes specified in each contract. The incentive system may be implemented for contract rate years beginning on or after July 1, 1996. The specified outcomes must be measurable and must be based on criteria to be developed by the commissioner. The commissioner may establish, for each contract, various levels of achievement within an outcome. After the outcomes have been specified the commissioner shall assign various levels of payment associated with achieving the outcome. Any incentive–based payment cancels if there is a termination of the contract. In establishing the specified outcomes and related criteria the commissioner shall consider the following state policy objectives:

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

(2) successful diversion or discharge to community alternatives;

(3) decreased acute care costs;

(4) improved consumer satisfaction;

(5) the achievement of quality; or

(6) any additional outcomes the commissioner finds desirable.

Subd. 5. **Private pay rates.** (a) Notwithstanding section 256B.48, subdivision 1, paragraph (a), the commissioner shall determine the maximum private pay case mix payment rates for nursing facilities that have entered into an alternative payment demonstration contract under this section as specified in this subdivision. Nothing in this section shall limit the exceptions for private pay rates authorized under section 256B.48, subdivision 1, paragraph (a).

(b) The maximum private pay rate for short–stay private paying residents who are discharged from the facility less than 101 days after admission is an amount equal to the greater of the Medicare payment rate for that facility or the resident's medical assistance case mix payment rate. For the first year of an alternative payment demonstration project contract the commissioner shall establish a maximum private paying rate for short–stay residents that is based on a nursing facility's estimated Medicare payment rate. When actual Medicare final rates are determined, the nursing facility shall retroactively adjust a private paying resident's rates and provide a refund or credit if the amount actually paid by the resident exceeds the amount that would have been paid using Medicare rates.

(c) When a private paying resident is admitted, a nursing facility shall determine, based on the resident's care plan, whether the resident is likely to be discharged less than 101 days after admission. If the resident is likely to be discharged less than 101 days after admission, the nursing facility may charge a short–stay private pay rate up to the maximum specified in paragraph (b). If the resident remains in the facility for longer than 100 days, the facility shall retroactively reduce the resident's payments to the maximum long–term rate specified in subdivision 4 effective from the date of admission and shall reimburse the resident for the overpayment. At the resident's option, the facility may reimburse residents for overpayments by providing a refund or a credit to be applied to future payments, or a combination of both, subject to the facility's right to offset for past–due payments. If the facility determines, based on the care plan, that the resident is likely to remain in the facility for longer than 100

days, the facility shall not charge a private pay rate greater than the maximum rate specified in subdivision 4.

(d) The provisions of paragraphs (b) and (c) do not apply to short–stay residents admitted prior to the effective date of a demonstration project contract.

Subd. 6. **Contract payment rates; appeals.** If an appeal is pending concerning the cost–based payment rates that are the basis for the calculation of the payment rate under the alternative payment demonstration project, the commissioner and the nursing facility may agree on an interim contract rate to be used until the appeal is resolved. When the appeal is resolved, the contract rate must be adjusted retroactively in accordance with the appeal decision.

Subd. 7. **Case mix assessments.** The commissioner may allow a contract facility to develop and implement a case mix assessment using the federal minimum data set resident assessment.

Subd. 8. **Optional higher payments for first 100 days.** The commissioner may include in the contract with a nursing facility under this section a higher rate for the first 100 days after admission than for subsequent days. The rate for the subsequent days must be reduced so that the estimated total cost to the medical assistance program will not exceed the estimated cost without the differential payment rates.

Subd. 9. **Managed care contracts for other services.** Beginning July 1, 1995, the commissioner may contract with nursing facilities that have entered into alternative payment demonstration project contracts under this section to provide medical assistance services other than nursing facility care to residents of the facility under a prepaid, managed care payment system. For purposes of contracts entered into under this subdivision, the commissioner may waive one or more of the requirements for payment for ancillary services in section 256B.433. Managed care contracts for other services may be entered into at any time during the duration of a nursing facility's alternative payment demonstration project contract, and the terms of the managed care contracts need not coincide with the terms of the alternative payment demonstration project contract.

Subd. 10. **Exemptions.** (a) To the extent permitted by federal law, (1) a facility that has entered into a contract under this section is not required to file a cost report, as defined in Minnesota Rules, part 9549.0020, subpart 13, for any year after the base year that is the basis for the calculation of the contract payment rate for the first rate year of the alternative payment demonstration project contract; and (2) a facility under contract is not subject to audits of historical costs or revenues, or paybacks or retroactive adjustments based on these costs or revenues, except audits, paybacks, or adjustments relating to the cost report that is the basis for calculation of the first rate year under the contract.

(b) A facility that is under contract with the commissioner under this section is not subject to the moratorium on licensure or certification of new nursing home beds in section 144A.071, unless the project results in a net increase in bed capacity or involves relocation of beds from one site to another. Contract payment rates must not be adjusted to reflect any additional costs that a nursing facility incurs as a result of a construction project undertaken under this paragraph. In addition, as a condition of entering into a contract under this section, a nursing facility must agree that any future medical assistance payments for nursing facility services will not reflect any additional costs attributable to the sale of a nursing facility under this section and to construction undertaken under this paragraph that otherwise would not be authorized under the moratorium in sections 144A.071 and 144A.073. Nothing in this section prevents a nursing facility participating in the alternative payment demonstration project under this section from seeking approval of an exception to the moratorium through the process established in section 144A.071, and if approved the facility's rates shall be adjusted to reflect the cost of the project.

(c) Notwithstanding section 256B.48, subdivision 6, paragraphs (c), (d), and (e), and pursuant to any terms and conditions contained in the facility's contract, a nursing facility that is under contract with the commissioner under this section is in compliance with section 256B.48, subdivision 6, paragraph (b), if the facility is Medicare certified.

(d) Notwithstanding paragraph (a), if by April 1, 1996, the health care financing administration has not approved a required waiver, or the health care financing administration

otherwise requires cost reports to be filed prior to the waiver's approval, the commissioner shall require a cost report for the rate year.

Subd. 11. **Consumer protection.** As a condition of entering into a contract under this section, a nursing facility must agree to establish resident grievance procedures that are similar to those required under section 256.045, subdivision 3. The commissioner may also require nursing facilities to establish expedited grievance procedures to resolve complaints made by short–stay residents. The facility must notify its resident council of its intent to enter into a contract and must consult with the council regarding any changes in operation expected as a result of the contract.

Subd. 12. **Contracts are voluntary.** Participation of nursing facilities in the alternative payment demonstration project is voluntary. The terms and procedures governing the alternative payment demonstration project are determined under this section and through negotiations between the commissioner and nursing facilities that have submitted a letter of intent to participate in the alternative demonstration project. For purposes of developing requests for proposals and contract requirements, and negotiating the terms, conditions, and requirements of contracts the commissioner is exempt from the rulemaking requirements in chapter 14.

Subd. 13. **Payment system reform advisory committee.** (a) The commissioner, in consultation with an advisory committee, shall study options for reforming the regulatory and reimbursement system for nursing facilities to reduce the level of regulation, reporting, and procedural requirements, and to provide greater flexibility and incentives to stimulate competition and innovation. The advisory committee shall include, at a minimum, representatives from the long–term care provider community, the department of health, and consumers of long–term care services. The advisory committee sunsets on June 30, 1997. Among other things, the commissioner shall consider the feasibility and desirability of changing from a certification requirement to an accreditation requirement for participation in the medical assistance program, options to encourage early discharge of short–term residents through the provision of intensive therapy, and further modifications needed in rate equalization. The commissioner shall also include detailed recommendations for a permanent managed care payment system to replace the contractual alternative payment demonstration project authorized under this section. The commissioner shall submit a report with findings and recommendations to the legislature by January 15, 1997.

(b) If a permanent managed care payment system has not been enacted into law by July 1, 1997, the commissioner shall develop and implement a transition plan to enable nursing facilities under contract with the commissioner under this section to revert to the cost–based payment system at the expiration of the alternative payment demonstration project. The commissioner shall include in the alternative payment demonstration project contracts entered into under this section a provision to permit an amendment to the contract to be made after July 1, 1997, governing the transition back to the cost–based payment system. The transition plan and contract amendments are not subject to rulemaking requirements.

Subd. 14. **Federal requirements.** The commissioner shall implement the contractual alternative payment demonstration project subject to any required federal waivers or approval and in a manner that is consistent with federal requirements. If a provision of this section is inconsistent with a federal requirement the federal requirement supersedes the inconsistent provision. The commissioner shall seek federal approval and request waivers as necessary to implement this section.

Subd. 15. **External review panel.** The commissioner may establish an external review panel consisting of persons appointed by the commissioner for their expertise on issues relating to nursing facility services, quality, payment systems, and other matters, to advise the commissioner on the development and implementation of the contractual alternative payment demonstration project and to assist the commissioner in assessing the quality of care provided and evaluating a facility's compliance with performance standards specified in a contract. The external review panel must include, among other members, representatives of nursing facilities.

Subd. 16. **Alternative contracts.** The commissioner may also contract with nursing facilities in other ways through requests for proposals, including contracts on a risk or nonrisk

(8) develop cost allocation principles which are based on facility expenses; and

(f) appeals procedures that satisfy the requirements of section 256B.50.

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

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 mental retardation. The commissioner of finance shall include annual inflation adjustments in operating costs for intermediate care facilities for persons with mental retardation and related conditions as a budget change request in each biennial detailed expenditure budget submitted to the legislature under section 16A.11. 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.

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

Subd. 3f. [Repealed, 1995 c 207 art 7 s 43]

Subd. 3g. **Assessment of clients.** (a) To establish the service characteristics of clients, the Minnesota department of health case mix review program shall assess all clients annually. The facility's qualified mental retardation professional (QMRP) with primary responsibility for the client's individual program plan, in conjunction with the interdisciplinary team, shall assess each client who is newly admitted to a facility. This assessment must occur within 30 days from the date of admission during the interdisciplinary team meeting.

(b) All client assessments must be conducted as set forth in the manual, Minnesota ICF/MR Client Assessment Manual, February 1995, hereinafter referred to in this subdivision as the manual. Client assessments completed by the case mix review program and the facility QMRP must be recorded on assessment forms developed by the commissioner of health. The facility QMRP must complete the assessment form, submit it to the case mix review program, and mail a copy to the client's case manager within ten working days following the interdisciplinary team meeting.

(c) The case mix review program shall score assessments according to attachment E of the manual in the assessment domains of personal interaction, independence, and integration, challenging behaviors and preventive practice, activities of daily living, and special treatments. Scores must be based on information from the assessment form. A client's score from each assessment domain shall be used to determine that client's classification.

(d) The commissioner of health shall determine and assign classifications for each client using the procedures specified in attachment F of the manual. The commissioner of health shall assign the client classification within 15 working days after receiving the completed assessment form submitted by the case mix review program team or the facility QMRP. The classification for a newly admitted client is effective retroactive to the date of the client's admission. If a facility QMRP submits an incomplete assessment form, the case mix review program shall inform the facility QMRP of the need to submit additional information

necessary for assigning a classification. The facility QMRP must mail the additional information to the case mix review program no later than five working days after receiving the request for the information. If a facility QMRP fails to submit a completed client assessment for a client who is newly admitted to the facility, that client's first assessment in the facility conducted by the case mix review program shall be used to establish a client classification retroactive to the date of the client's admission. Any change in classification due to annual assessment by the case mix review program will be effective on the first day of the month following completion of the case mix review program's annual assessment of all the facility's clients. A client who has resided in the facility less than 30 days must be assessed by the case mix review program during the annual assessment, but must not have a client classification assigned based on the case mix review program's assessment unless the facility QMRP fails to submit a completed client assessment and the client goes on to reside in the facility for more than 30 days.

(e) The facility QMRP may request a reclassification for a client by completing a new client assessment if the facility QMRP believes that the client's status has changed since the case mix review program's annual assessment and that these changes will result in a change in the client's classification. Client assessments for purposes of reclassification will be governed by the following:

(1) The facility QMRP that requests reclassification of a client must provide the case mix review program with evidence to determine a change in the client's classification. Evidence must include photocopies of documentation from the client's record, as specified in the documentation requirements sections of the manual.

(2) A reclassification assessment must occur between the third and the ninth month following the case mix review program's annual assessment of the client. The facility QMRP can request only one reclassification for each client annually.

(3) Any change in classification approved by the case mix review program shall be effective on the first day of the month following the date when the facility QMRP assessed the client for the reclassification.

(4) The case mix review program shall determine reclassification based on the documentation submitted by the facility QMRP. If there is not sufficient information submitted to justify a change to a higher classification, the case mix review program may request additional information necessary to complete a reclassification.

(5) If the facility QMRP does not provide sufficient documentation to support a change in classification, the classification shall remain at the level assessed by the case mix review program at the last inspection of care.

(f) The case mix review program shall conduct desk audits or on–site audits of assessments performed by facility QMRPs. Case mix review program staff shall conduct desk audits of any assessment believed to be inaccurate. The case mix review program may request the facility to submit additional information needed to conduct a desk audit. The facility shall mail the requested information within five working days after receiving the request.

(g) The case mix review program may conduct on–site audits of at least ten percent of the total assessments submitted by facility QMRPs in the previous year and may also conduct special audits if it determines that circumstances exist that could change or affect the validity of assigned classifications. The facility shall grant the case mix review program staff access to the client records during regular business hours for the purpose of conducting an audit. For assessments submitted for new clients, the case mix review program shall consider documentation in the client's record up to and including the date the client was assessed by the facility QMRP. For audits of reclassification assessments, the case mix review program shall consider documentation in the client's record from three months preceding the assessment up to and including the date the client was assessed by the facility QMRP. If the audit reveals that the facility's assessment does not accurately reflect the client's status for the time period and the appropriate supporting documentation cannot be produced by the facility, the case mix review program shall change the classification so that it is consistent with the results of the audit. Any change in client classification that results from an audit must be retroactive to the effective date of the client assessment that was audited. Case mix review program staff shall not discuss preliminary audit findings with the facility's staff. Within 15 working days

after completing the audit, the case mix review program shall mail a notice of the results of the audit to the facility.

(h) Requests for reconsideration of client classifications shall be made under section 144.0723 and must be submitted according to section IV of the manual. A reconsideration must be reviewed by case mix review program staff not involved in completing the assessment that established the disputed classification. The reconsideration must be based upon the information provided to the case mix review program. Within 15 working days after receiving the request for reconsideration, the case mix review program shall affirm or modify the original classification. The original classification must be modified if the case mix review program determines that the assessment resulting in the classification did not accurately reflect the status of the client at the time of the assessment. The department of health's decision on reconsiderations is the final administrative decision of the department. The classification assigned by the department of health must be the classification that applies to the client while the request for reconsideration is pending. A change in a classification resulting from a reconsideration must be retroactive to the effective date of the client assessment for which a reconsideration was requested.

(i) The commissioner of human services shall assign weights to each client's classification according to the following table:

Classification	Classification Weight
1S	1.00
1I	1.04
2S	1.36
2I	1.52
3S	1.58
3I	1.68
4S	1.87
4I	2.02
5S	2.09
5I	2.26
6S	2.26
6I	2.52
7S	2.10
7I	2.37
8S	2.26
8I	2.52

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

Subd. 3l. **Temporary payment rate provisions.** If an intermediate care facility for persons with mental retardation or related conditions located in Kandiyohi county:

(1) was sold during 1994;

(2) is unable to obtain records necessary to complete the cost report from the former operator at no cost; and

(3) delicensed two beds during that year, then the commissioner shall determine the payment rate for the period May 1, 1995, through September 30, 1996, as provided in paragraphs (a) to (c).

(a) A temporary payment rate shall be paid which is equal to the rate in effect as of April 30, 1995.

(b) The payment rate in paragraph (a) shall be subject to a retroactive downward adjustment based on the provisions in paragraph (c).

(c) The temporary payment rate shall be limited to the lesser of the payment in paragraph (a) or the payment rate calculated based on the facility's cost report for the reporting year January 1, 1995, through December 31, 1995, and the provisions of this section and the reimbursement rules in effect on June 30, 1995, except that the provisions referred to in clauses (1) to (3) shall not apply:

(1) the inflation factor in subdivision 3c;

(2) Minnesota Rules, part 9553.0050, subpart 2, items A to E; and

(3) Minnesota Rules, part 9553.0041, subpart 16.

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

Subd. 5b. **ICF/MR operating cost limitation after September 30, 1995.** (a) For rate years beginning on October 1, 1995, and October 1, 1996, the commissioner shall limit the allowable operating cost per diems, as determined under this subdivision and the reimbursement rules, for high cost ICF's/MR. Prior to indexing each facility's operating cost per diems for inflation, the commissioner shall group the facilities into eight groups. The commissioner shall then array all facilities within each grouping by their general operating cost per service unit per diems.

(b) The commissioner shall annually review and adjust the general operating costs incurred by the facility during the reporting year preceding the rate year to determine the facility's allowable historical general operating costs. For this purpose, the term general operating costs means the facility's allowable operating costs included in the program, maintenance, and administrative operating costs categories, as well as the facility's related payroll taxes and fringe benefits, real estate insurance, and professional liability insurance. A facility's total operating cost payment rate shall be limited according to paragraphs (c) and (d) as follows:

(c) A facility's total operating cost payment rate shall be equal to its allowable historical operating cost per diems for program, maintenance, and administrative cost categories multiplied by the forecasted inflation index in subdivision 3c, clause (1), subject to the limitations in paragraph (d).

(d) For the rate years beginning on or after October 1, 1995, the commissioner shall establish maximum overall general operating cost per service unit limits for facilities according to clauses (1) to (8). Each facility's allowable historical general operating costs and client assessment information obtained from client assessments completed under subdivision 3g for the reporting year ending December 31, 1994 (the base year), shall be used for establishing the overall limits. If a facility's proportion of temporary care resident days to total resident days exceeds 80 percent, the commissioner must exempt that facility from the overall general operating cost per service unit limits in clauses (1) to (8). For this purpose, "temporary care" means care provided by a facility to a client for less than 30 consecutive resident days.

(1) The commissioner shall determine each facility's weighted service units for the reporting year by multiplying its resident days in each client classification level as established in subdivision 3g, paragraph (d), by the corresponding weights for that classification level, as established in subdivision 3g, paragraph (i), and summing the results. For the reporting year ending December 31, 1994, the commissioner shall use the service unit score computed from the client classifications determined by the Minnesota department of health's annual review, including those of clients admitted during that year.

(2) The facility's service unit score is equal to its weighted service units as computed in clause (1), divided by the facility's total resident days excluding temporary care resident days, for the reporting year.

(3) For each facility, the commissioner shall determine the facility's cost per service unit by dividing its allowable historical general operating costs for the reporting year by the facility's service unit score in clause (2) multiplied by its total resident days, or 85 percent of the facility's capacity days times its service unit score in clause (2), if the facility's occupancy is less than 85 percent of licensed capacity. If a facility reports temporary care resident days, the temporary care resident days shall be multiplied by the service unit score in clause (2), and the resulting weighted resident days shall be added to the facility's weighted service units in clause (1) prior to computing the facility's cost per service unit under this clause.

(4) The commissioner shall group facilities based on class A or class B licensure designation, number of licensed beds, and geographic location. For purposes of this grouping, facilities with six beds or less shall be designated as small facilities and facilities with more than six beds shall be designated as large facilities. If a facility has both class A and class B licensed beds, the facility shall be considered a class A facility for this purpose if the number of class A beds is more than half its total number of ICF/MR beds; otherwise the facility shall be considered a class B facility. The metropolitan geographic designation shall include Ano-

basis, with nursing facilities or consortia of nursing facilities, to provide comprehensive long–term care coverage on a premium or capitated basis.

Subd. 17. **Report.** The commissioner shall report to the legislature by January 15, 1997, regarding the impact of the alternative payment demonstration project. In assessing the impact, the commissioner may examine elements of the project including consumer satisfaction, quality of care, adequacy of services, timeliness in the delivery of services, and other elements determined appropriate by the commissioner. In developing this report, the commissioner may involve appropriate consumer advocate groups as needed to assist in monitoring and evaluating changes in a nursing facility's behavior, including the monitoring and evaluation of issues involving resident protection. The report must include recommendations for reimbursement of nursing homes after June 30, 1997, based on experience with the demonstration project.

History: *1995 c 207 art 7 s 32*

256B.49 CHRONICALLY ILL CHILDREN AND DISABLED PERSONS; HOME AND COMMUNITY–BASED WAIVER STUDY AND APPLICATION.

Subdivision 1. **Study; waiver application.** The commissioner shall authorize a study to assess the need for home and community–based waivers for chronically ill children who have been and will continue to be hospitalized without a waiver, and for disabled individuals under the age of 65 who are likely to reside in an acute care or nursing home facility in the absence of a waiver. If a need for these waivers can be demonstrated, the commissioner shall apply for federal waivers necessary to secure, to the extent allowed by law, federal participation under United States Code, title 42, sections 1396–1396p, as amended through December 31, 1982, for the provision of home and community–based services to chronically ill children who, in the absence of such a waiver, would remain in an acute care setting, and to disabled individuals under the age of 65 who, in the absence of a waiver, would reside in an acute care or nursing home setting. If the need is demonstrated, the commissioner shall request a waiver under United States Code, title 42, sections 1396–1396p, to allow medicaid eligibility for blind or disabled children with ineligible parents where income deemed from the parents would cause the applicant to be ineligible for supplemental security income if the family shared a household and to furnish necessary services in the home or community to disabled individuals under the age of 65 who would be eligible for medicaid if institutionalized in an acute care or nursing home setting. These waivers are requested to furnish necessary services in the home and community setting to children or disabled adults under age 65 who are medicaid eligible when institutionalized in an acute care or nursing home setting. The commissioner shall assure that the cost of home and community–based care will not be more than the cost of care if the eligible child or disabled adult under age 65 were to remain institutionalized. The commissioner shall seek to amend the federal waivers obtained under this section to apply criteria to protect against spousal impoverishment as authorized under United States Code, title 42, section 1396r–5, and as implemented in sections 256B.0575, 256B.058, and 256B.059, except that the amendment shall seek to add to the personal needs allowance permitted in section 256B.0575, an amount equivalent to the group residential housing rate as set by section 256I.03, subdivision 5.

[For text of subds 2 to 5, see M.S.1994]

Subd. 6. **Admission certification.** In determining an individual's eligibility for the community alternative care waiver program, and an individual's eligibility for medical assistance under section 256B.055, subdivision 12, paragraph (b), the commissioner may review or contract for review of the individual's medical condition to determine level of care using criteria in Minnesota Rules, parts 9505.0520 to 9505.0540.

For purposes of this subdivision, a person requires long–term care in an inpatient hospital setting if the person has an ongoing condition that is expected to last one year or longer, and would require continuous or frequent hospitalizations during that period, but for the provision of home care services under this section.

Subd. 7. **Persons with developmental disabilities or related conditions.** Individuals who apply for services under the community alternatives for disabled individuals (CADI)

waiver program who have developmental disabilities or related conditions must be screened for the appropriate institutional level of care in accordance with section 256B.092.

History: *1995 c 207 art 6 s 87–89*

256B.501 RATES FOR COMMUNITY–BASED SERVICES FOR PERSONS WITH MENTAL RETARDATION OR RELATED CONDITIONS.

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

(a) "Commissioner" means the commissioner of human services.

(b) "Facility" means a facility licensed as a mental retardation 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 mental retardation or related conditions. The term does not include a state regional treatment center.

(c) "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.

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

Subd. 3. **Rates for intermediate care facilities for persons with mental retardation or related conditions.** The commissioner shall establish, by rule, procedures for determining rates for care of residents of intermediate care facilities for persons with mental retardation or related conditions. In developing the procedures, the commissioner shall include:

(a) 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;

(b) limits on the amounts of reimbursement for property and new facilities;

(c) requirements to ensure that the accounting practices of the facilities conform to generally accepted accounting principles;

(d) incentives to reward accumulation of equity;

(e) rule revisions which:

(1) combine the program, maintenance, and administrative operating cost categories, and professional liability and real estate insurance expenses into one general operating cost category;

(2) 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 clause (3);

(3) 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;

(4) establish a best practices award system that is based on outcome measures and that rewards quality, innovation, cost–effectiveness, and staff retention;

(5) 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;

(6) 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;

(7) utilize the client assessment information obtained from the application of the provisions in subdivision 3g for the revisions in clauses (3), (4), and (6); and

ka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington counties. All other Minnesota counties shall be designated as the nonmetropolitan geographic group. These characteristics result in the following eight groupings:

(i) small class A metropolitan;

(ii) large class A metropolitan;

(iii) small class B metropolitan;

(iv) large class B metropolitan;

(v) small class A nonmetropolitan;

(vi) large class A nonmetropolitan;

(vii) small class B nonmetropolitan; and

(viii) large class B nonmetropolitan.

(5) The commissioner shall array facilities within each grouping in clause (4) by each facility's cost per service unit as determined in clause (3).

(6) In each array established under clause (5), facilities with a cost per service unit at or above the median shall be limited to the lesser of: (i) the current reporting year's cost per service unit; or (ii) the prior reporting year's allowable historical general operating cost per service unit plus the inflation factor as established in subdivision 3c, clause (2), increased by three percentage points.

(7) The overall operating cost per service unit limit for each group shall be established as follows:

(i) each array established under clause (5) shall be arrayed again after the application of clause (6);

(ii) in each array established in clause (5), two general operating cost limits shall be determined. The first cost per service unit limit shall be established at 0.5 and less than or equal to 1.0 standard deviation above the median of that array. The second cost per service unit limit shall be established at 1.0 standard deviation above the median of the array; and

(iii) the overall operating cost per service unit limits shall be indexed for inflation annually beginning with the reporting year ending December 31, 1995, using the forecasted inflation index in subdivision 3c, clause (2).

(8) Annually, facilities shall be arrayed using the method described in clauses (5) and (7). Each facility with a cost per service unit at or above its group's first cost per service unit limit, but less than the second cost per service unit limit for that group, shall be limited to 98 percent of its total operating cost per diems then add the forecasted inflation index in subdivision 3c, clause (1). Each facility with a cost per service unit at or above the second cost per service unit limit will be limited to 97 percent of its total operating cost per diems, then add the forecasted inflation index in subdivision 3c, clause (1).

(9) The commissioner may rebase these overall limits, using the method described in this subdivision but no more frequently than once every three years.

(e) For rate years beginning on or after October 1, 1995, the facility's efficiency incentive shall be determined as provided in the reimbursement rule.

(f) The total operating cost payment rate shall be the sum of paragraphs (c) and (e).

Subd. 5c. **Operating costs after September 30, 1997.** (a) In general, the commissioner shall establish maximum standard rates for the prospective reimbursement of facility costs. The maximum standard rates must take into account the level of reimbursement which is adequate to cover the base–level costs of economically operated facilities. In determining the base–level costs, the commissioner shall consider geographic location, types of facilities (class A or class B), minimum staffing standards, resident assessment under subdivision 3g, and other factors as determined by the commissioner.

(b) The commissioner shall also develop additional incentive–based payments which, if achieved for specified outcomes, will be added to the maximum standard rates. The specified outcomes must be measurable and shall be based on criteria to be developed by the commissioner during fiscal year 1996. The commissioner may establish various levels of achievement within an outcome. Once the outcomes are established, the commissioner shall assign various levels of payment associated with achieving the outcome. In establishing the

specified outcomes and the related criteria, the commissioner shall consider the following state policy objectives:

(1) resident transitioned into cost–effective community alternatives;

(2) the results of a uniform consumer satisfaction survey;

(3) the achievement of no major licensure or certification deficiencies; or

(4) any other outcomes the commissioner finds desirable.

(c) In developing the maximum standard rates and the incentive–based payments, desirable outcomes, and related criteria, the commissioner, in collaboration with the commissioner of health, shall form an advisory committee. The membership of the advisory committee shall include representation from the consumers advocacy groups (3), the two facility trade associations (3 each), counties (3), commissioner of finance (1), the legislature (2 each from both the house and senate), and others the commissioners find appropriate.

(d) Beginning July 1, 1996, the commissioner shall collect the data from the facilities, the department of health, or others as necessary to determine the extent to which a facility has met any of the outcomes and related criteria. Payment rates under this subdivision shall be effective October 1, 1997.

(e) The commissioner shall report to the legislature on the progress of the advisory committee by January 31, 1996, any necessary changes to the reimbursement methodology proposed under this subdivision. By January 15, 1997, the commissioner shall recommend to the legislature legislation which will implement this reimbursement methodology for rate years beginning on or after the proposed effective date of October 1, 1997.

Subd. 8. **Payment for persons with special needs.** The commissioner shall establish by December 31, 1983, procedures to be followed by the counties to seek authorization from the commissioner for medical assistance reimbursement for very dependent persons with special needs in an amount in excess of the rates allowed pursuant to subdivision 2, including rates established under section 252.46 when they apply to services provided to residents of intermediate care facilities for persons with mental retardation or related conditions, and procedures to be followed for rate limitation exemptions for intermediate care facilities for persons with mental retardation or related conditions. Rate payments under subdivision 8a are eligible for a rate exception under this subdivision. No excess payment approved by the commissioner after June 30, 1991, shall be authorized unless:

(1) the need for specific level of service is documented in the individual service plan of the person to be served;

(2) the level of service needed can be provided within the rates established under section 252.46 and Minnesota Rules, parts 9553.0010 to 9553.0080, without a rate exception within 12 months;

(3) staff hours beyond those available under the rates established under section 252.46 and Minnesota Rules, parts 9553.0010 to 9553.0080, necessary to deliver services do not exceed 1,440 hours within 12 months;

(4) there is a basis for the estimated cost of services;

(5) the provider requesting the exception documents that current per diem rates are insufficient to support needed services;

(6) estimated costs, when added to the costs of current medical assistance–funded residential and day training and habilitation services and calculated as a per diem, do not exceed the per diem established for the regional treatment centers for persons with mental retardation and related conditions on July 1, 1990, indexed annually by the urban consumer price index, all items, as forecasted by Data Resources Inc., for the next fiscal year over the current fiscal year;

(7) any contingencies for an approval as outlined in writing by the commissioner are met; and

(8) any commissioner orders for use of preferred providers are met.

The commissioner shall evaluate the services provided pursuant to this subdivision through program and fiscal audits.

The commissioner may terminate the rate exception at any time under any of the conditions outlined in Minnesota Rules, part 9510.1120, subpart 3, for county termination, or by

reason of information obtained through program and fiscal audits which indicate the criteria outlined in this subdivision have not been, or are no longer being, met.

The commissioner may approve no more than one rate exception, up to 12 months duration, for an eligible client.

Subd. 8a. **Payment for persons with special needs for crisis intervention services.** State–operated, community–based crisis services provided in accordance with section 252.50, subdivision 7, to a resident of an intermediate care facility for persons with mental retardation (ICF/MR) reimbursed under this section shall be paid by medical assistance in accordance with the paragraphs (a) to (h).

(a) "Crisis services" means the specialized services listed in clauses (1) to (3) provided to prevent the recipient from requiring placement in a more restrictive institutional setting such as an inpatient hospital or regional treatment center and to maintain the recipient in the present community setting.

(1) The crisis services provider shall assess the recipient's behavior and environment to identify factors contributing to the crisis.

(2) The crisis services provider shall develop a recipient–specific intervention plan in coordination with the service planning team and provide recommendations for revisions to the individual service plan if necessary to prevent or minimize the likelihood of future crisis situations. The intervention plan shall include a transition plan to aid the recipient in returning to the community–based ICF/MR if the recipient is receiving residential crisis services.

(3) The crisis services provider shall consult with and provide training and ongoing technical assistance to the recipient's service providers to aid in the implementation of the intervention plan and revisions to the individual service plan.

(b) "Residential crisis services" means crisis services that are provided to a recipient admitted to the crisis services foster care setting because the ICF/MR receiving reimbursement under this section is not able, as determined by the commissioner, to provide the intervention and protection of the recipient and others living with the recipient that is necessary to prevent the recipient from requiring placement in a more restrictive institutional setting.

(c) Crisis services providers must be licensed by the commissioner under section 245A.03 to provide foster care, must exclusively provide short–term crisis intervention, and must not be located in a private residence.

(d) Payment rates are determined annually for each crisis services provider based on cost of care for each provider as defined in section 246.50. Interim payment rates are calculated on a per diem basis by dividing the projected cost of providing care by the projected number of contact days for the fiscal year, as estimated by the commissioner. Final payment rates are calculated by dividing the actual cost of providing care by the actual number of contact days in the applicable fiscal year.

(e) Payment shall be made for each contact day. "Contact day" means any day in which the crisis services provider has face–to–face contact with the recipient or any of the recipient's medical assistance service providers for the purpose of providing crisis services as defined in paragraph (c).

(f) Payment for residential crisis services is limited to 21 days, unless an additional period is authorized by the commissioner. The additional period may not exceed 21 days.

(g) Payment for crisis services shall be made only for services provided while the ICF/MR receiving reimbursement under this section:

(1) has a shared services agreement with the crisis services provider in effect in accordance with section 246.57;

(2) has reassigned payment for the provision of the crisis services under this subdivision to the commissioner in accordance with Code of Federal Regulations, title 42, section 447.10(e); and

(3) 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.

(h) Payment to the ICF/MR receiving reimbursement under this section shall be made for up to 18 therapeutic leave days during which the recipient is receiving residential crisis services, if the ICF/MR is otherwise eligible to receive payment for a therapeutic leave day under Minnesota Rules, part 9505.0415. Payment under this paragraph shall be terminated if the commissioner determines that the ICF/MR is not meeting the terms of the cooperative agreement under paragraph (g) or that the recipient will not return to the ICF/MR.

[For text of subds 10 to 12, see M.S.1994]

History: *1995 c 114 s 1; 1995 c 207 art 7 s 33–40*

NOTE: Subdivisions 3d and 3e are repealed for rate years beginning after September 30, 1996. See Laws 1995, chapter 207, article 7, section 43, subdivision 2.

256B.504 [Repealed, 1995 c 248 art 2 s 8]

256B.69 PREPAYMENT DEMONSTRATION PROJECT.

[For text of subd 1, see M.S.1994]

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 an individual, agency, organization, or group of these entities that participates in the demonstration project according to criteria, standards, methods, and other requirements established for the project and approved by the commissioner.

(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.

(e) This paragraph supersedes paragraph (c) as long as the Minnesota health care reform waiver remains in effect. When the waiver expires, this paragraph expires and the commissioner of human services shall publish a notice in the State Register and notify the revisor of statutes. "Eligible individuals" means those persons eligible for medical assistance benefits as defined in sections 256B.055, 256B.056, and 256B.06. Notwithstanding sections 256B.055, 256B.056, and 256B.06, an individual who becomes ineligible for the program because of failure to submit income reports or recertification forms in a timely manner, shall remain enrolled in the prepaid health plan and shall remain eligible to receive medical assistance coverage through the last day of the month following the month in which the enrollee became ineligible for the medical assistance program.

[For text of subd 3, see M.S.1994]

Subd. 3a. **County authority.** The commissioner, when implementing the general assistance medical care or medical assistance prepayment program within a county, must include the county board in the process of development, approval, and issuance of the request for proposals to provide services to eligible individuals within the proposed county. County boards must be given reasonable opportunity to make recommendations regarding the development, issuance, review of responses, and changes needed in the request for proposals. The commissioner must provide county boards the opportunity to review each proposal based on the identification of community needs under chapters 145A and 256E and county advocacy activities. If a county board finds that a proposal does not address certain community needs, the county board and commissioner shall continue efforts for improving the proposal and network prior to the approval of the contract. The county board shall make recommendations regarding the approval of local networks and their operations to ensure adequate availability and access to covered services. The provider or health plan must respond directly to county advocates and the state prepaid medical assistance ombudsperson regarding service delivery

and must be accountable to the state regarding contracts with medical assistance and general assistance medical care funds. The county board may recommend a maximum number of participating health plans after considering the size of the enrolling population; ensuring adequate access and capacity; considering the client and county administrative complexity; and considering the need to promote the viability of locally developed health plans. Prior to the development of the request for proposal, there shall be established a mutually agreed upon timetable. This process shall in no way delay the department's ability to secure and finalize contracts for the medical assistance prepayment program.

Subd. 4. **Limitation of choice.** 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. 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 are eligible for medical assistance according to section 256B.055, subdivision 12, or (iii) unless 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; and (5) recipients who receive benefits under the Refugee Assistance Program, established under United States Code, title 8, section 1522(e). Children under age 21 who are in foster placement may enroll in the project on an elective basis. 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. Before limitation of choice is implemented, eligible individuals shall be notified and after notification, shall be allowed to choose only among demonstration providers. 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.

Subd. 4a. **Requirements of request for proposal.** In implementing the limitation of choice for persons eligible for medical assistance according to section 256B.055, subdivision 12, hereinafter referred to as TEFRA recipients, the commissioner shall comply with the request for proposal process applicable to the prepaid medical assistance program. Notwithstanding any provision to the contrary, the commissioner shall include the following in the request for proposal issued to health plans for purposes of covering TEFRA recipients:

(1) evidence that eligibility criteria for personal care assistant services have been developed and implemented with respect to TEFRA recipients;

(2) a complete and detailed description of the benefits the health plan is responsible for providing to the TEFRA recipients;

(3) identification of the circumstances under which and the point at which the health plan covering the TEFRA recipient pursuant to this section is responsible for the costs of and delivery of benefits to the TEFRA recipient. The purpose of this information is to facilitate coordination of benefits with private health plans, including self-insured employers who are covering the TEFRA recipients. The point at which and circumstances under which the health plan is responsible must be identified and developed so as to be applied consistently to all TEFRA recipients;

(4) statistical information including the following:

(i) how many TEFRA recipients will be enrolled;

(ii) historical cost and utilization information, by type of service and diagnosis or condition, and any other data or statistics used in developing the proposed rate of payment to the health plan;

(iii) average cost per TEFRA recipient to the state; and

(iv) outlier information, including diagnosis categories, cost, and the number of TEFRA recipients; and

(5) actuarially valid rates of payment proposed to be paid to the health plans.

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. Notwithstanding section 62D.02, subdivision 1, payments for services rendered as part of the project may be made to providers that are not licensed health maintenance organizations on a risk–based, prepaid capitation basis.

If allowed by the commissioner, a demonstration provider may contract with an insurer, health care provider, nonprofit health service plan corporation, or the commissioner, to provide insurance or similar protection against the cost of care provided by the demonstration provider or to provide coverage against the risks incurred by demonstration providers under this section. The recipients enrolled with a demonstration provider are a permissible group under group insurance laws and chapter 62C, the Nonprofit Health Service Plan Corporations Act. Under this type of contract, the insurer or corporation may make benefit payments to a demonstration provider for services rendered or to be rendered to a recipient. Any insurer or nonprofit health service plan corporation licensed to do business in this state is authorized to provide this insurance or similar protection.

Payments to providers participating in the project are exempt from the requirements of sections 256.966 and 256B.03, subdivision 2. The commissioner shall complete development of capitation rates for payments before delivery of services under this section is begun. For payments made during calendar year 1990 and later years, the commissioner shall contract with an independent actuary to establish prepayment rates.

By January 15, 1996, the commissioner shall report to the legislature on the methodology used to allocate to participating counties available administrative reimbursement for advocacy and enrollment costs. The report shall reflect the commissioner's judgment as to the adequacy of the funds made available and of the methodology for equitable distribution of the funds. The commissioner must involve participating counties in the development of the report.

Subd. 5a. **Managed care contracts.** Managed care contracts under this section, sections 256.9363, and 256D.03, shall be entered into or renewed on a calendar year basis beginning January 1, 1996. Managed care contracts which were in effect on June 30, 1995, and set to renew on July 1, 1995, shall be renewed for the period July 1, 1995 through December 31, 1995 at the same terms that were in effect on June 30, 1995.

Subd. 5b. **Prospective reimbursement rates.** For prepaid medical assistance and general assistance medical care program contract rates effective January 1, 1996, through December 31, 1996, capitation rates for nonmetropolitan counties shall on a weighted average be no less than 85 percent of the capitation rates for metropolitan counties, excluding Hennepin county.

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 and for children eligible for medical assistance under section 256B.055, subdivision 12, home care services and personal care assistant services in order to ensure appropriate health care is delivered to enrollees;

(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.

[For text of subds 7 and 8, see M.S.1994]

Subd. 9. **Reporting.** 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 collection from county advocacy activities 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.

[For text of subds 10 to 17, see M.S.1994]

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 to providers not affiliated with a 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, and the general assistance medical care rates for general assistance medical care enrollees, paid by the commissioner of human services to providers for services to recipients not enrolled in a prepaid health plan.

Subd. 20. **Ombudsperson.** The commissioner shall designate an ombudsperson to advocate for persons required to enroll in prepaid health plans under this section. The ombudsperson shall advocate for recipients enrolled in prepaid health plans through complaint and appeal procedures and ensure that necessary medical services are provided either by the prepaid health plan directly or by referral to appropriate social services. At the time of enrollment in a prepaid health plan, the local agency shall inform recipients about the ombudsperson program and their right to a resolution of a complaint by the prepaid health plan if they experience a problem with the plan or its providers.

Subd. 21. **Prepayment coordinator.** The local agency shall designate a prepayment coordinator to assist the state agency in implementing this section and section 256D.03, subdivision 4. Assistance must include educating recipients about available health care options, enrolling recipients under subdivision 5, providing necessary eligibility and enrollment information to health plans and the state agency, and coordinating complaints and appeals with the ombudsman established in subdivision 18.

Subd. 22. **Impact on public or teaching hospitals and community clinics.** (a) Before implementing prepaid programs in counties with a county operated or affiliated public teaching hospital or a hospital or clinic operated by the University of Minnesota, the commissioner shall consider the risks the prepaid program creates for the hospital and allow the county or hospital the opportunity to participate in the program, provided the terms of participation in the program are competitive with the terms of other participants.

(b) Prepaid health plans serving counties with a nonprofit community clinic or community health services agency must contract with the clinic or agency to provide services to clients who choose to receive services from the clinic or agency, if the clinic or agency agrees to payment rates that are competitive with rates paid to other health plan providers for the same or similar services.

Subd. 23. **Alternative integrated long–term care services; elderly and disabled persons.** (a) The commissioner may implement demonstration projects to create alternative integrated delivery systems for acute and long–term care services to elderly and disabled persons 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. Medicare funds and services shall be administered according to the terms and conditions of the federal waiver and demonstration provisions. For the purpose of administering medical assistance funds, demonstrations under this subdivision are subject to subdivisions 1 to 17. 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 elderly persons enrolling in demonstrations 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 256.9363, 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 to serve only elderly persons eligible for medical assistance, elderly and disabled persons, or disabled persons only.

Before implementation of a demonstration project for disabled persons, the commissioner must provide information to appropriate committees of the house of representatives and senate and must involve representatives of affected disability groups in the design of the demonstration projects.

(b) 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.

History: *1995 c 207 art 6 s 90–102; art 7 s 41; 1995 c 234 art 6 s 40,41*

NOTE: The amendment to subdivision 4 by Laws 1995, chapter 207, article 6, section 91, requiring children eligible for medical assistance under section 256B.055, subdivision 12, to participate in managed care is effective July 1, 1996. See Laws 1995, chapter 207, article 6, section 125, subdivision 6.

NOTE: The amendment to subdivision 6 by Laws 1995, chapter 207, article 6, section 96, is effective July 1, 1996. See Laws 1995, chapter 207, article 6, section 125, subdivision 7.

256B.691 RISK–BASED TRANSPORTATION PAYMENTS.

Any contract with a prepaid health plan under the medical assistance, general assistance medical care, or MinnesotaCare program that requires the health plan to cover transportation services for obtaining medical care for eligible individuals who are ambulatory must provide for payment for those services on a risk basis.

History: *1995 c 207 art 6 s 103*