CHAPTER 256B

MEDICAL ASSISTANCE FOR NEEDY PERSONS

256B.037 PROSPECTIVE PAYMENT OF DENTAL SERVICES.

[For text of subd 1, see M.S.1996]

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

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

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

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

[For text of subds 1b to 9, see M.S.1996]

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

[For text of subd 11, see M.S.1996]

History: *1997 c 203 art 9 s 9; 1997 c 225 art 2 s 62*

256B.04 DUTIES OF STATE AGENCY.

[For text of subd 1, see M.S.1996]

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

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

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

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

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

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

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

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

[For text of subds 3 to 10, see M.S.1996]

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

[For text of subds 12 to 17, see M.S.1996]

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 256L.03, subdivision 3, paragraph (b).

History: *1997 c 7 art 1 s 101; 1997 c 203 art 4 s 18*

256B.042 THIRD PARTY LIABILITY.

Subdivision 1. **Lien for cost of care.** When the state agency provides, pays for, or becomes liable for medical care, it shall have a lien for the cost of the care upon any and all causes of action or recovery rights under any policy, plan, or contract providing benefits for health care or injury, which accrue to the person to whom the care was furnished, or to the person's legal representatives, as a result of the illness or injuries which necessitated the medical care.

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

(b) The state agency is not subject to any limitations period referred to in section 514.69 or 514.71 and has one year from the date notice is first received by it under subdivision 4,

paragraph (c), even if the notice is untimely, or one year from the date medical bills are first paid by the state agency, whichever is later, to file its verified lien statement. The state agency may commence an action to enforce the lien within one year of (1) the date the notice required by subdivision 4, paragraph (c), is received or (2) the date the recipient's cause of action is concluded by judgment, award, settlement, or otherwise, whichever is later. For purposes of this section, "state agency" includes authorized agents of the state agency.

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

[For text of subd 3, see M.S.1996]

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

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

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

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

(1) when a claim is filed;

(2) when an action is commenced; and

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

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

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

[For text of subd 5, see M.S.1996]

History: *1997 c 217 art 2 s 5–7*

256B.055 ELIGIBILITY CATEGORIES.

[For text of subds 1 and 2, see M.S.1996]

Subd. 3. **AFDC families.** Until March 31, 1998, medical assistance may be paid for a person who is eligible for or receiving, or who would be eligible for, except for excess income or assets, public assistance under the aid to families with dependent children program in effect as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law Number 104–193.

Subd. 3a. **MFIP–S families; families eligible under prior AFDC rules.** (a) Beginning January 1, 1998, or on the date that MFIP–S is implemented in counties, medical assistance may be paid for a person receiving public assistance under the MFIP–S program.

(b) Beginning January 1, 1998, medical assistance may be paid for a person who would have been eligible for public assistance under the income and resource standards and deprivation requirements, or who would have been eligible but for excess income or assets, under the state's AFDC plan in effect as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law Number 104–193.

[For text of subd 4, see M.S.1996]

Subd. 5. **Pregnant women; dependent unborn child.** Medical assistance may be paid for a pregnant woman who has written verification of a positive pregnancy test from a physician or licensed registered nurse, who meets the other eligibility criteria of this section and who would be categorically eligible for assistance under the state's AFDC plan in effect as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law Number 104–193, if the child had been born and was living with the woman. For purposes of this subdivision, a woman is considered pregnant for 60 days postpartum.

[For text of subds 6 to 11, see M.S.1996]

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. After the child is determined to be eligible under this section, the commissioner shall review the child's disability under United States Code, title 42, section 1382c(a) and level of care defined under this section no more often than annually and may elect, based on the recommendation of health care professionals under contract with the state medical review team, to extend the review of disability and level of care up to a maximum of four years. The commissioner's decision on the frequency of continuing review of disability and level of care is not subject to administrative appeal under section 256.045. Nothing in this subdivision shall be construed as affecting other redeterminations of medical assistance eligibility under this chapter and annual cost–effective reviews under this section.

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

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

(c) For purposes of this subdivision, "nursing facility" means a facility which provides nursing care as defined in section 144A.01, subdivision 5, licensed pursuant to sections 144A.02 to 144A.10, which is appropriate if a person is in active restorative treatment; is in need of special treatments provided or supervised by a licensed nurse; or has unpredictable

episodes of active disease processes requiring immediate judgment by a licensed nurse. For purposes of this subdivision, a child requires the level of care provided in a nursing facility if the child is determined by the commissioner to meet the requirements of the preadmission screening assessment document under section 256B.0911 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) For purposes of this subdivision, a person requires the level of care provided in a nursing facility if the person requires 24–hour monitoring or supervision and a plan of mental health treatment because of specific symptoms or functional impairments associated with a serious mental illness or disorder diagnosis, which meet severity criteria for mental health established by the commissioner and published in March 1997 as the Minnesota Mental Health Level of Care for Children and Adolescents with Severe Emotional Disorders.

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

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

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

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

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

(h) 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: *1997 c 85 art 3 s 10–12; 1997 c 203 art 4 s 19*

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

[For text of subd 1, see M.S.1996]

Subd. 1a. **Income and assets generally.** Unless specifically required by state law or rule or federal law or regulation, the methodologies used in counting income and assets to determine eligibility for medical assistance for persons whose eligibility category is based on blindness, disability, or age of 65 or more years, the methodologies for the supplemental security income program shall be used, except that payments made according to a court order for the support of children shall be excluded from income in an amount not to exceed the difference between the applicable income standard used in the state's medical assistance program for aged, blind, and disabled persons and the applicable income standard used in the state's medical assistance program for families with children. Exclusion of court–ordered child support payments is subject to the condition that if there has been a change in the financial circumstances of the person with the legal obligation to pay support since the support order was entered, the person with the legal obligation to pay support has petitioned for modification of the support order. For families and children, which includes all other eligibility categories, the methodologies under the state's AFDC plan in effect as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law Number 104–193, shall be used. Effective upon federal approval, in–kind contributions to, and payments made on behalf of, a recipient, by an obligor, in satisfaction of or in addition to a temporary or permanent order for child support or maintenance, shall be considered income to the recipient. For these purposes, a "methodology" does not include an asset or income standard, or accounting method, or method of determining effective dates.

[For text of subd 2, see M.S.1996]

Subd. 3. **Asset limitations.** To be eligible for medical assistance, a person must not individually own more than $3,000 in assets, or if a member of a household with two family members,husband and wife, or parent and child, the household must not own more than $6,000 in assets, plus $200 for each additional legal dependent. In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. The accumulation of the clothing and personal needs allowance according to section 256B.35 must also be reduced to the maximum at the time of the eligibility redetermination. The value of assets that are not considered in determining eligibility for medical assistance is the value of those assets excluded under the AFDC state plan as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law Number 104–193, for families and children, and the supplemental security income program for aged, blind, and disabled persons, with the following exceptions:

(a) Household goods and personal effects are not considered.

(b) Capital and operating assets of a trade or business that the local agency determines are necessary to the person's ability to earn an income are not considered.

(c) Motor vehicles are excluded to the same extent excluded by the supplemental security income program.

(d) Assets designated as burial expenses are excluded to the same extent excluded by the supplemental security income program.

[For text of subd 3b, see M.S.1996]

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 under the aid to families with dependent children state plan as of July 16, 1996,

as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law Number 104–193, 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 and Veterans Administration unusual medical expense payments are considered income to the recipient.

[For text of subds 4a and 4b, see M.S.1996]

Subd. 5. **Excess income.** A person who has excess income is eligible for medical assistance if the person has expenses for medical care that are more than the amount of the person's excess income, computed by deducting incurred medical expenses from the excess income to reduce the excess to the income standard specified in subdivision 4. The person shall elect to have the medical expenses deducted at the beginning of a one–month budget period or at the beginning of a six–month budget period. The commissioner shall allow persons eligible for assistance on a one–month spenddown basis under this subdivision to elect to pay the monthly spenddown amount in advance of the month of eligibility to the state agency in order to maintain eligibility on a continuous basis. If the recipient does not pay the spenddown amount on or before the 20th of the month, the recipient is ineligible for this option for the following month. The local agency shall code the Medicaid Management Information System (MMIS) to indicate that the recipient has elected this option. The state agency shall convey recipient eligibility information relative to the collection of the spenddown to providers through the Electronic Verification System (EVS). A recipient electing advance payment must pay the state agency the monthly spenddown amount on or before the 20th of the month in order to be eligible for this option in the following month.

[For text of subds 5a to 7, see M.S.1996]

Subd. 8. **Cooperation.** To be eligible for medical assistance, applicants and recipients must cooperate with the state and local agency to identify potentially liable third–party payers and assist the state in obtaining third party payments, unless good cause for noncooperation is determined according to Code of Federal Regulations, title 42, part 433.147. "Cooperation" includes identifying any third party who may be liable for care and services provided under this chapter to the applicant, recipient, or any other family member for whom application is made and providing relevant information to assist the state in pursuing a potentially liable third party. Cooperation also includes providing information about a group health plan for which the person may be eligible and if the plan is determined cost–effective by the state agency and premiums are paid by the local agency or there is no cost to the recipient, they must enroll or remain enrolled with the group. For purposes of this subdivision, coverage provided by the Minnesota comprehensive health association under chapter 62E shall not be considered group health plan coverage or cost–effective by the state and local agency. Cost–effective insurance premiums approved for payment by the state agency and paid by the local agency are eligible for reimbursement according to section 256B.19.

History: *1997 c 85 art 3 s 13–15; 1997 c 203 art 4 s 20,21; 1997 c 225 art 6 s 4*

NOTE: The amendment to subdivision 8 by Laws 1997, chapter 225, article 6, section 4, expires June 30, 1999. Laws 1997, chapter 225, article 6, section 8.

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

Subdivision 1. **Pregnant women and infants.** (a) An infant less than one year 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 under the state's AFDC plan as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law Number 104–193, except for the earned in-

come 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 under the state's AFDC plan as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law Number 104–193, exceeds 275 percent of the federal poverty guideline will be deducted for pregnant women and infants less than one year of age.

(b) 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 first birthday, as long as the child remains in the woman's household.

Subd. 1a. **Premiums.** Women and infants who are eligible under subdivision 1 and whose countable family income is equal to or greater than 185 percent of the federal poverty guideline for the same family size shall be required to pay a premium for medical assistance coverage based on a sliding scale as established under section 256L.08.

Subd. 1b. **Pregnant women and infants; expansion.** (a) 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 under the state's AFDC plan as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law Number 104–193, 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 under the state's AFDC plan as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law Number 104–193, exceeds 275 percent of the federal poverty guideline will be deducted for pregnant women and infants less than two years of age.

(b) 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.

Subd. 2. **Children.** A child one through five years of age in a family whose countable income is less than 133 percent of the federal poverty guidelines for the same family size, is eligible for medical assistance. A child six through 18 years of age, who was born after September 30, 1983, in a family whose countable income is less than 100 percent of the federal poverty guidelines for the same family size is eligible for medical assistance.

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

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

[For text of subds 3 to 6, see M.S.1996]

History: *1997 c 85 art 3 s 16,17; 1997 c 203 art 4 s 22–24*

NOTE: Subdivision 2b was also amended by Laws 1997, chapter 85, article 3, section 18, to read as follows:

"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 under the state's AFDC plan in effect as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law Number 104–193, 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."

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.

Subd. 1a. **Institutionalized spouse.** The provisions of this section apply only when a spouse is institutionalized for a continuous period beginning on or after October 1, 1989.

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

[For text of subds 3 and 4, see M.S.1996]

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

(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 com-

munity 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: *1997 c 107 s 3–6*

256B.06 ELIGIBILITY; MIGRANT WORKERS; CITIZENSHIP.

[For text of subd 3, see M.S.1996]

Subd. 4. **Citizenship requirements.** (a) Eligibility for medical assistance is limited to citizens of the United States, qualified noncitizens as defined in this subdivision, and other persons residing lawfully in the United States.

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

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

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

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

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

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

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

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

(c) All qualified noncitizens who were residing in the United States before August 22, 1996, who otherwise meet the eligibility requirements of chapter 256B, are eligible for medical assistance with federal financial participation.

(d) All qualified noncitizens who entered the United States on or after August 22, 1996, and who otherwise meet the eligibility requirements of chapter 256B, are eligible for medical assistance with federal financial participation through November 30, 1996.

Beginning December 1, 1996, qualified noncitizens who entered the United States on or after August 22, 1996, and who otherwise meet the eligibility requirements of chapter 256B are eligible for medical assistance with federal participation for five years if they meet one of the following criteria:

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

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

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

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

(v) persons on active duty in the United States Armed Forces, other than for training, their spouses and unmarried minor dependent children.

Beginning December 1, 1996, qualified noncitizens who do not meet one of the criteria in items (i) to (v) are eligible for medical assistance without federal financial participation as described in paragraph (j).

(e) Noncitizens who are not qualified noncitizens as defined in paragraph (b), who are lawfully residing in the United States and who otherwise meet the eligibility requirements of chapter 256B, are eligible for medical assistance under clauses (1) to (3). These individuals must cooperate with the Immigration and Naturalization Service to pursue any applicable immigration status, including citizenship, that would qualify them for medical assistance with federal financial participation.

(1) Persons who were medical assistance recipients on August 22, 1996, are eligible for medical assistance with federal financial participation through December 31, 1996.

(2) Beginning January 1, 1997, persons described in clause (1) are eligible for medical assistance without federal financial participation as described in paragraph (j).

(3) Beginning December 1, 1996, persons residing in the United States prior to August 22, 1996, who were not receiving medical assistance and persons who arrived on or after August 22, 1996, are eligible for medical assistance without federal financial participation as described in paragraph (j).

(f) Nonimmigrants who otherwise meet the eligibility requirements of chapter 256B are eligible for the benefits as provided in paragraphs (g) to (i). For purposes of this subdivision, a "nonimmigrant" is a person in one of the classes listed in United States Code, title 8, section 1101(a)(15).

(g) Payment shall also be made for care and services that are furnished to noncitizens, regardless of immigration status, who otherwise meet the eligibility requirements of chapter 256B, if such care and services are necessary for the treatment of an emergency medical condition, except for organ transplants and related care and services and routine prenatal care.

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

(i) Pregnant noncitizens who are undocumented or nonimmigrants, who otherwise meet the eligibility requirements of chapter 256B, are eligible for medical assistance payment without federal financial participation for care and services through the period of pregnancy, and 60 days postpartum, except for labor and delivery.

(j) Qualified noncitizens as described in paragraph (d), and all other noncitizens lawfully residing in the United States as described in paragraph (e), who are ineligible for medical assistance with federal financial participation and who otherwise meet the eligibility requirements of chapter 256B and of this paragraph, are eligible for medical assistance without federal financial participation. Qualified noncitizens as described in paragraph (d) are only eligible for medical assistance without federal financial participation for five years from their date of entry into the United States.

(k) The commissioner shall submit to the legislature by December 31, 1998, a report on the number of recipients and cost of coverage of care and services made according to paragraphs (i) and (j).

Subd. 5. **Deeming of sponsor income and resources.** When determining eligibility for any federal or state funded medical assistance under this section, the income and resources of all noncitizens shall be deemed to include their sponsors' income and resources as required under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, title IV, Public Law Number 104–193, sections 421 and 422, and subsequently set out in federal rules. This section is effective May 1, 1997.

History: *1997 c 85 art 3 s 19,20; 1997 c 203 art 12 s 2*

256B.062 CONTINUED ELIGIBILITY.

Medical assistance may be paid for persons who received aid to families with dependent children in at least three of the six months preceding the month in which the person became

ineligible for aid to families with dependent children, if the ineligibility was due to an increase in hours of employment or employment income or due to the loss of an earned income disregard. A person who is eligible for extended medical assistance is entitled to six months of assistance without reapplication, unless the assistance unit ceases to include a dependent child. For a person under 21 years of age, medical assistance may not be discontinued within the six–month period of extended eligibility until it has been determined that the person is not otherwise eligible for medical assistance. Medical assistance may be continued for an additional six months if the person meets all requirements for the additional six months, according to Title XIX of the Social Security Act, as amended by section 303 of the Family Support Act of 1988, Public Law Number 100–485. This section is repealed effective March 31, 1998.

History: *1997 c 85 art 3 s 21*

256B.0625 COVERED SERVICES.

[For text of subds 1 to 12, see M.S.1996]

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, vitamins for children under the age of seven and pregnant or nursing women, and any other over-the-counter drug identified by the commissioner, in consultation with the 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;

(iii) anorectics;

(iv) drugs for which medical value has not been established; and

(v) drugs from manufacturers who have not signed a rebate agreement with the Department of Health and Human Services pursuant to section 1927 of title XIX of the Social Security Act and who have not signed an agreement with the state for drugs purchased pursuant to the senior citizen drug program established under section 256.955.

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 $3.65. 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.

[For text of subd 13a, see M.S.1996]

Subd. 13b. [Repealed, 1997 c 203 art 4 s 73]

Subd. 14. **Diagnostic, screening, and preventive services.** (a) Medical assistance covers diagnostic, screening, and preventive services.

(b) "Preventive services" include services related to pregnancy, including:

(1) services for those conditions which may complicate a pregnancy and which may be available to a pregnant woman determined to be at risk of poor pregnancy outcome;

(2) prenatal HIV risk assessment, education, counseling, and testing; and

(3) alcohol abuse assessment, education, and counseling on the effects of alcohol usage while pregnant. Preventive services available to a woman at risk of poor pregnancy outcome may differ in an amount, duration, or scope from those available to other individuals eligible for medical assistance.

(c) "Screening services" include, but are not limited to, blood lead tests.

Subd. 15. **Health plan premiums and copayments.** (a) Medical assistance covers health care prepayment plan premiums, insurance premiums, and copayments if determined to be cost-effective by the commissioner. For purposes of obtaining Medicare part A and part B, and copayments, expenditures may be made even if federal funding is not available.

(b) Effective for all premiums due on or after June 30, 1997, medical assistance does not cover premiums that a recipient is required to pay under a qualified or Medicare supplement plan issued by the Minnesota comprehensive health association. Medical assistance shall continue to cover premiums for recipients who are covered under a plan issued by the Minnesota comprehensive health association on June 30, 1997, for a period of six months following receipt of the notice of termination or until December 31, 1997, whichever is later.

[For text of subds 16 to 31, see M.S.1996]

Subd. 31a. **Augmentative and alternative communication systems.** (a) Medical assistance covers augmentative and alternative communication systems consisting of electronic or nonelectronic devices and the related components necessary to enable a person with severe expressive communication limitations to produce or transmit messages or symbols in a manner that compensates for that disability.

(b) By January 1, 1998, the commissioner, in cooperation with the commissioner of administration, shall establish an augmentative and alternative communication system purchasing program within a state agency or by contract with a qualified private entity. The purpose of this service is to facilitate ready availability of the augmentative and alternative communication systems needed to meet the needs of persons with severe expressive communication limitations in an efficient and cost–effective manner. This program shall:

(1) coordinate purchase and rental of augmentative and alternative communication systems;

(2) negotiate agreements with manufacturers and vendors for purchase of components of these systems, for warranty coverage, and for repair service;

(3) when efficient and cost–effective, maintain and refurbish if needed, an inventory of components of augmentative and alternative communication systems for short– or long–term loan to recipients;

(4) facilitate training sessions for service providers, consumers, and families on augmentative and alternative communication systems; and

(5) develop a recycling program for used augmentative and alternative communications systems to be reissued and used for trials and short–term use, when appropriate.

The availability of components of augmentative and alternative communication systems through this program is subject to prior authorization requirements established under subdivision 25.

Reimbursement rates established by this purchasing program are not subject to Minnesota Rules, part 9505.0445, item S or T.

[For text of subds 32 to 40, see M.S.1996]

History: *1997 c 203 art 2 s 25; art 4 s 25,26; 1997 c 225 art 4 s 3; art 6 s 5*

NOTE: The amendment to subdivision 15 by Laws 1997, chapter 225, article 6, section 5, expires June 30, 1999. Laws 1997, chapter 225, article 6, section 8.

256B.0626 ESTIMATION OF 50TH PERCENTILE OF PREVAILING CHARGES.

(a) The 50th percentile of the prevailing charge for the base year identified in statute must be estimated by the commissioner in the following situations:

(1) there were less than five billings in the calendar year specified in legislation governing maximum payment rates;

(2) the service was not available in the calendar year specified in legislation governing maximum payment rates;

(3) the payment amount is the result of a provider appeal;

(4) the procedure code description has changed since the calendar year specified in legislation governing maximum payment rates, and, therefore, the prevailing charge information reflects the same code but a different procedure description; or

(5) the 50th percentile reflects a payment which is grossly inequitable when compared with payment rates for procedures or services which are substantially similar.

(b) When one of the situations identified in paragraph (a) occurs, the commissioner shall use the following methodology to reconstruct a rate comparable to the 50th percentile of the prevailing rate:

(1) refer to information which exists for the first four billings in the calendar year specified in legislation governing maximum payment rates; or

(2) refer to surrounding or comparable procedure codes; or

(3) refer to the 50th percentile of years subsequent to the calendar year specified in legislation governing maximum payment rates, and reduce that amount by applying an appropriate Consumer Price Index formula; or

(4) refer to relative value indexes; or

(5) refer to reimbursement information from other third parties, such as Medicare.

History: *1997 c 203 art 4 s 27*

256B.0627 COVERED SERVICE; HOME CARE SERVICES.

[For text of subds 1 to 4, see M.S.1996]

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 home care services during a calendar year:

(1) any initial assessment;

(2) up to two reassessments per year done to determine a recipient's need for personal care services; and

(3) up to five skilled nurse visits.

(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;

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

(5) the professional nurse determines an immediate need for up to 40 skilled nursing or home health aide visits per calendar year and submits a request for authorization within 20 working days of the initial service date, and medical assistance is determined to be the appropriate payer.

(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 at a time for up to three years.

(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 licensed nurse or a home health aide 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, for care provided in a regional treatment center for recipients who have Level I behavior, plus any inflation adjustment as provided by the legislature for personal care service; or

(D) 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

(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 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 including children and adults under 65 years of age. 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 the recipient's 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, primary payer coverage determination information as required, the service plan, the recipient's age, the cost of services, the recipient's medical condition, and diagnosis or disability. The commissioner may publish additional criteria for determining medical necessity according to section 256B.04.

(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, and primary payer coverage determination information as required. Authorization for a temporary level of home care services including nurse supervision is limited to the time specified by the commissioner, but shall not exceed 45 days, 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. Requests for home care services for recipients residing in a foster care setting must include the foster care placement agreement and determination of difficulty of care;

(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 unless the county responsible for the recipient's foster placement made the placement prior to April 1, 1992, requests that home care services be provided, and case management is provided as required in section 256B.0625, subdivision 19a; 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.

[For text of subds 6 and 7, see M.S.1996]

Subd. 8. **Personal care assistant services.** Recipients of personal care assistant services may share staff and the commissioner shall provide a rate system for shared personal care assistant services. The rate system shall not exceed 1–1/2 the amount paid for providing services to one person, and shall increase incrementally by one–half the cost of serving a single person, for each person served. A personal care assistant may not serve more than three children in a single setting.

Nothing in this subdivision shall be construed to reduce the total number of hours authorized for an individual recipient.

History: *1997 c 203 art 4 s 28,29*

256B.0629 ADVISORY COMMITTEE ON ORGAN AND TISSUE TRANSPLANTS.

[For text of subds 1 and 2, see M.S.1996]

Subd. 3. [Repealed, 1997 c 7 art 2 s 67]

[For text of subd 4, see M.S.1996]

256B.0635 CONTINUED ELIGIBILITY IN SPECIAL CIRCUMSTANCES.

Subdivision 1. **Increased employment.** Beginning January 1, 1998, medical assistance may be paid for persons who received MFIP–S or medical assistance for families and children in at least three of six months preceding the month in which the person became ineligible for MFIP–S or medical assistance, if the ineligibility was due to an increase in hours of employment or employment income or due to the loss of an earned income disregard. In addition, to receive continued assistance under this section, persons who received medical assistance for families and children but did not receive MFIP–S must have had income less than or equal to the assistance standard for their family size under the state's AFDC plan in effect as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law Number 104–193, at the time medical assistance eligibility began. A person who is eligible for extended medical assistance is entitled to six months of assistance without reapplication, unless the assistance unit ceases to include a dependent child. For a person under 21 years of age, medical assistance may not be

discontinued within the six–month period of extended eligibility until it has been determined that the person is not otherwise eligible for medical assistance. Medical assistance may be continued for an additional six months if the person meets all requirements for the additional six months, according to title XIX of the Social Security Act, as amended by section 303 of the Family Support Act of 1988, Public Law Number 100–485.

Subd. 2. **Increased child or spousal support.** Beginning January 1, 1998, medical assistance may be paid for persons who received MFIP–S or medical assistance for families and children in at least three of the six months preceding the month in which the person became ineligible for MFIP–S or medical assistance, if the ineligibility was the result of the collection of child or spousal support under part D of title IV of the Social Security Act. In addition, to receive continued assistance under this section, persons who received medical assistance for families and children but did not receive MFIP–S must have had income less than or equal to the assistance standard for their family size under the state's AFDC plan in effect as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law Number 104–193, at the time medical assistance eligibility began. A person who is eligible for extended medical assistance under this subdivision is entitled to four months of assistance without reapplication, unless the assistance unit ceases to include a dependent child. For a person under 21 years of age, medical assistance may not be discontinued within the four–month period of extended eligibility until it has been determined that the person is not otherwise eligible for medical assistance.

History: *1997 c 85 art 3 s 22*

256B.064 INELIGIBLE PROVIDER.

[For text of subd 1, see M.S.1996]

Subd. 1a. **Grounds for monetary recovery and sanctions against vendors.** The commissioner may seek monetary recovery and impose sanctions against vendors of medical care for any of the following: fraud, theft, or abuse in connection with the provision of medical care to recipients of public assistance; a pattern of presentment of false or duplicate claims or claims for services not medically necessary; a pattern of making false statements of material facts for the purpose of obtaining greater compensation than that to which the vendor is legally entitled; suspension or termination as a Medicare vendor; refusal to grant the state agency access during regular business hours to examine all records necessary to disclose the extent of services provided to program recipients; and any reason for which a vendor could be excluded from participation in the Medicare program under section 1128, 1128A, or 1866(b)(2) of the Social Security Act. The determination of services not medically necessary may be made by the commissioner in consultation with a peer advisory task force appointed by the commissioner on the recommendation of appropriate professional organizations. The task force expires as provided in section 15.059, subdivision 5.

[For text of subd 1b, see M.S.1996]

Subd. 1c. **Methods of monetary recovery.** The commissioner may obtain monetary recovery from a vendor who has been improperly paid either as a result of conduct described in subdivision 1a or as a result of a vendor or department error, regardless of whether the error was intentional. The commissioner may obtain monetary recovery using methods, including but not limited to the following: assessing and recovering money improperly paid and debiting from future payments any money improperly paid. Patterns need not be proven as a precondition to monetary recovery of erroneous or false claims, duplicate claims, claims for services not medically necessary, or claims based on false statements. The commissioner shall charge interest on money to be recovered if the recovery is to be made by installment payments or debits, except when the monetary recovery is of an overpayment that resulted from a department error. The interest charged shall be the rate established by the commissioner of revenue under section 270.75.

[For text of subd 1d, see M.S.1996]

Subd. 2. **Imposition of monetary recovery and sanctions.** (a) The commissioner shall determine monetary amounts to be recovered and the sanction to be imposed upon a vendor

of medical care for conduct described by subdivision 1a. Except as provided in paragraph (b), neither a monetary recovery nor a sanction will be imposed by the commissioner without prior notice and an opportunity for a hearing, according to chapter 14, on the commissioner's proposed action, provided that the commissioner may suspend or reduce payment to a vendor of medical care, except a nursing home or convalescent care facility, after notice and prior to the hearing if in the commissioner's opinion that action is necessary to protect the public welfare and the interests of the program.

(b) Except for a nursing home or convalescent care facility, the commissioner may withhold or reduce payments to a vendor of medical care without providing advance notice of such withholding or reduction if either of the following occurs:

(1) the vendor is convicted of a crime involving the conduct described in subdivision 1a; or

(2) the commissioner receives reliable evidence of fraud or willful misrepresentation by the vendor.

(c) The commissioner must send notice of the withholding or reduction of payments under paragraph (b) within five days of taking such action. The notice must:

(1) state that payments are being withheld according to paragraph (b);

(2) except in the case of a conviction for conduct described in subdivision 1a, state that the withholding is for a temporary period and cite the circumstances under which withholding will be terminated;

(3) identify the types of claims to which the withholding applies; and

(4) inform the vendor of the right to submit written evidence for consideration by the commissioner.

The withholding or reduction of payments will not continue after the commissioner determines there is insufficient evidence of fraud or willful misrepresentation by the vendor, or after legal proceedings relating to the alleged fraud or willful misrepresentation are completed, unless the commissioner has sent notice of intention to impose monetary recovery or sanctions under paragraph (a).

(d) Upon receipt of a notice under paragraph (a) that a monetary recovery or sanction is to be imposed, a vendor may request a contested case, as defined in section 14.02, subdivision 3, by filing with the commissioner a written request of appeal. The appeal request must be received by the commissioner no later than 30 days after the date the notification of monetary recovery or sanction was mailed to the vendor. The appeal request must specify:

(1) each disputed item, the reason for the dispute, and an estimate of the dollar amount involved for each disputed item;

(2) the computation that the vendor believes is correct;

(3) the authority in statute or rule upon which the vendor relies for each disputed item;

(4) the name and address of the person or entity with whom contacts may be made regarding the appeal; and

(5) other information required by the commissioner.

History: *1997 c 203 art 4 s 30–32*

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 programs or contractor for state employees established under section 43A.18, the public employees insurance program under section 43A.316, for health insurance plans offered to local statutory or home rule charter city, county, and school district employees, the workers' compensation system under section 176.135, and insurance plans provided through the Minnesota comprehensive health association under sections 62E.01 to 62E.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, (2) for providers other than dental services providers, 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, or (3) for dental services providers, at least ten 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: *1997 c 203 art 4 s 33*

NOTE: The amendment to this section by Laws 1997, chapter 203, article 4, section 33, expires on June 30, 1999. Laws 1997, chapter 203, article 4, section 72.

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

Payment to a provider for a health care service provided to a general assistance medical care recipient who is later determined eligible for medical assistance or MinnesotaCare according to section 256L.14 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.071 MEDICARE MAXIMIZATION PROGRAM.

Subdivision 1. **Definition.** (a) "Dual entitlees" means recipients eligible for either the medical assistance program or the alternative care program who are also eligible for the federal Medicare program.

(b) For purposes of this section, "home care services" means home health agency services, private duty nursing services, personal care assistant services, waivered services, alternative care program services, hospice services, rehabilitation therapy services, and suppliers of medical supplies and equipment.

[For text of subd 2, see M.S.1996]

Subd. 3. **Referrals to Medicare providers required.** Non–Medicare certified home care providers and medical suppliers that do not participate or accept Medicare assignment must refer and document the referral of dual eligible recipients to Medicare providers when Medicare is determined to be the appropriate payer for services and supplies and equipment. Providers will be terminated from participation in the medical assistance program for failure to make such referrals.

Subd. 4. **Medicare certification requirement.** Medicare certification is required of all medical assistance enrolled home care service providers as required under Title XIX of the Social Security Act.

[For text of subd 5, see M.S.1996]

History: *1997 c 195 s 2–4*

256B.0911 NURSING FACILITY PREADMISSION SCREENING.

[For text of subd 1, see M.S.1996]

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;

(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; or

(6) individuals who are admitted to a certified nursing facility for a short–term stay, which, based upon a physician's certification, is expected to be 14 days or less in duration, and who have been screened and approved for nursing facility admission within the previous six months. This exemption applies only if the screener determines at the time of the initial screening of the six–month period that it is appropriate to use the nursing facility for short–term stays and that there is an adequate plan of care for return to the home or community–based setting. If a stay exceeds 14 days, the individual must be referred no later than the first county working day following the 14th resident day for a screening, which must be completed within five working days of the referral. Payment limitations in subdivision 7 will apply to an individual found at screening to not meet the level of care criteria for admission to a certified nursing facility.

Regardless of the exemptions in clauses (2) to (6), persons who have a diagnosis or possible diagnosis of mental illness, mental retardation, or a related condition must receive a preadmission screening 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 nursing 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.

[For text of subds 2a to 6, see M.S.1996]

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 by the commissioner of health according to section 144.0722 and determined to 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, 1998.

(b) 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 if persons were admitted to the program on or after July 1, 1998. 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).

(c) 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).

(d) 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.

(e) 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.1996]

History: *1997 c 203 art 4 s 34; art 9 s 10; 1997 c 225 art 8 s 6*

256B.0912 ALTERNATIVE CARE AND WAIVERED SERVICE PROGRAMS.

[For text of subds 1 and 2, see M.S.1996]

Subd. 3. **Rate consolidation and equalization.** (a) The commissioner of human services shall use one maximum reimbursement rate for personal care services rendered after June 30, 1997, regardless of whether the services are provided through the medical assistance program, the alternative care program, and the elderly, the community alternatives for disabled individuals, the community alternative care, and the traumatic brain injury waiver programs. The maximum reimbursement rate to be paid must be the reimbursement rate paid for personal care services received under the medical assistance program on June 30, 1997.

(b) The maximum reimbursement rates for behavior programming and cognitive therapy services provided through the traumatic brain injury waiver must be equivalent to the medical assistance reimbursement rates for mental health services.

History: *1997 c 203 art 4 s 35*

256B.0913 ALTERNATIVE CARE PROGRAM.

[For text of subds 1 to 4, see M.S.1996]

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;

(17) training for direct informal caregivers; and

(18) telemedicine devices to monitor recipients in their own homes as an alternative to hospital care, nursing home care, or home visits.

(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) A county may use alternative care funds to purchase medical supplies and equipment without prior approval from the commissioner when: (1) there is no other funding source; (2) the supplies and equipment are specified in the individual's care plan as medically necessary to enable the individual to remain in the community according to the criteria in Minnesota Rules, part 9505.0210, item A; and (3) the supplies and equipment represent an effective and appropriate use of alternative care funds. 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 recre-

ational 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 which are not subject to registration under chapter 144D. 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 157.011 and 157.15 to 157.22.

(i) For establishments registered under chapter 144D, assisted living services under this section means the services described and licensed under section 144A.4605.

(j) 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 based on an individualized service plan for each resident. 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, unless the services are provided by a home care provider licensed

by the department of health and are provided in a building that is registered as a housing with services establishment under chapter 144D and that provides 24–hour supervision.

(k) 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.

(l) 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 subd 6, see M.S.1996]

Subd. 7. **Case management.** Providers of case management services for persons receiving services funded by the alternative care program must meet the qualification requirements and standards specified in section 256B.0915, subdivision 1b. The case manager must ensure the health and safety of the individual client and is responsible for the cost–effectiveness of the alternative care individual care plan. The county may allow a case manager employed by the county to delegate certain aspects of the case management activity to another individual employed by the county provided there is oversight of the individual by the case manager. The case manager may not delegate those aspects which require professional judgment including assessments, reassessments, and care plan development.

[For text of subds 8 and 9, see M.S.1996]

Subd. 10. **Allocation formula.** (a) The alternative care appropriation for fiscal years 1992 and beyond shall cover only 180–day eligible clients.

(b) Prior to July 1 of each year, the commissioner shall allocate to county agencies the state funds available for alternative care for persons eligible under subdivision 2. The allocation for fiscal year 1992 shall be calculated using a base that is adjusted to exclude the medical assistance share of alternative care expenditures. The adjusted base is calculated by multiplying each county's allocation for fiscal year 1991 by the percentage of county alternative care expenditures for 180–day eligible clients. The percentage is determined based on expenditures for services rendered in fiscal year 1989 or calendar year 1989, whichever is greater.

(c) If the county expenditures for 180–day eligible clients are 95 percent or more of its adjusted base allocation, the allocation for the next fiscal year is 100 percent of the adjusted base, plus inflation to the extent that inflation is included in the state budget.

(d) If the county expenditures for 180–day eligible clients are less than 95 percent of its adjusted base allocation, the allocation for the next fiscal year is the adjusted base allocation less the amount of unspent funds below the 95 percent level.

(e) For fiscal year 1992 only, a county may receive an increased allocation if annualized service costs for the month of May 1991 for 180–day eligible clients are greater than the allocation otherwise determined. A county may apply for this increase by reporting projected expenditures for May to the commissioner by June 1, 1991. The amount of the allocation may exceed the amount calculated in paragraph (b). The projected expenditures for May must be

based on actual 180–day eligible client caseload and the individual cost of clients' care plans. If a county does not report its expenditures for May, the amount in paragraph (c) or (d) shall be used.

(f) Calculations for paragraphs (c) and (d) are to be made as follows: for each county, the determination of expenditures shall be based on payments for services rendered from April 1 through March 31 in the base year, to the extent that claims have been submitted by June 1 of that year. Calculations for paragraphs (c) and (d) must also include the funds transferred to the consumer support grant program for clients who have transferred to that program from April 1 through March 31 in the base year.

[For text of subds 11 to 13, see M.S.1996]

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) 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.

(d) 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.

(e) 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, 1998, 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. The allocation will be distributed by a population based formula and shall not exceed the proportion of projected savings made available under section 144.0721, subdivision 3.

(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 special allocation under this section to a county is not sufficient to serve all persons who qualify for the service allowance, the county is not required to provide any services to a high function class A person but shall establish a waiting list to provide services as special allocation funding becomes available.

[For text of subds 15a to 15c, see M.S.1996]

Subd. 16. **Conversion of enrollment.** Upon approval of the elderly waiver amendments described in section 256B.0915, subdivision 1d, persons currently receiving services

shall have their eligibility for the elderly waiver program determined under section 256B.0915. Persons currently receiving alternative care services whose income is under the special income standard according to Code of Federal Regulations, title 42, section 435.236, who are eligible for the elderly waiver program shall be transferred to that program and shall receive priority access to elderly waiver slots for six months after implementation of this subdivision. Persons currently enrolled in the alternative care program who are not eligible for the elderly waiver program shall continue to be eligible for the alternative care program as long as continuous eligibility is maintained. Continued eligibility for the alternative care program shall be reviewed every six months. Persons who apply for the alternative care program after approval of the elderly waiver amendments in section 256B.0915, subdivision 1d, are not eligible for alternative care if they would qualify for the elderly waiver, with or without a spenddown.

History: *1997 c 113 s 17; 1997 c 203 art 4 s 36–39; art 11 s 6; 1997 c 225 art 8 s 3*

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

[For text of subds 1 and 1a, see M.S.1996]

Subd. 1b. **Provider qualifications and standards.** The commissioner must enroll qualified providers of elderly case management services under the home and community–based waiver for the elderly under section 1915(c) of the Social Security Act. The enrollment process shall ensure the provider's ability to meet the qualification requirements and standards in this subdivision and other federal and state requirements of this service. An elderly case management provider is an enrolled medical assistance provider who is determined by the commissioner to have all of the following characteristics:

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

(2) administrative capacity and experience in serving the target population for whom it will provide services and in ensuring quality of services under state and federal requirements;

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

(4) the capacity to document and maintain individual case records under state and federal requirements; and

(5) the county may allow a case manager employed by the county to delegate certain aspects of the case management activity to another individual employed by the county provided there is oversight of the individual by the case manager. The case manager may not delegate those aspects which require professional judgment including assessments, reassessments, and care plan development.

[For text of subd 1c, see M.S.1996]

Subd. 1d. **Posteligibility treatment of income and resources for elderly waiver.** (a) Notwithstanding the provisions of section 256B.056, the commissioner shall make the following amendment to the medical assistance elderly waiver program effective July 1, 1997, or upon federal approval, whichever is later.

A recipient's maintenance needs will be an amount equal to the Minnesota supplemental aid equivalent rate as defined in section 256I.03, subdivision 5, plus the medical assistance personal needs allowance as defined in section 256B.35, subdivision 1, paragraph (a), when applying posteligibility treatment of income rules to the gross income of elderly waiver recipients, except for individuals whose income is in excess of the special income standard according to Code of Federal Regulations, title 42, section 435.236.

(b) The commissioner of human services shall secure approval of additional elderly waiver slots sufficient to serve persons who will qualify under the revised income standard described in paragraph (a) before implementing section 256B.0913, subdivision 16.

[For text of subd 2, see M.S.1996]

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 be the greater of the monthly payment for: (i) 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; or (ii) the statewide average payment of the case mix resident class to which the resident would be assigned under the medical assistance case mix reimbursement system, provided that the limit under this clause only applies to persons discharged from a nursing facility and found eligible for waivered services on or after July 1, 1997. 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, private duty nursing, 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) For both the elderly waiver and the nursing facility disabled waiver, a county may purchase extended supplies and equipment without prior approval from the commissioner when there is no other funding source and the supplies and equipment are specified in the individual's care plan as medically necessary to enable the individual to remain in the community according to the criteria in Minnesota Rules, part 9505.0210, items A and B. 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 based on an individualized service plan for each resident. 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, unless the services are provided by a home care provider licensed by the department of health and are provided in a building that is registered as a housing with services establishment under chapter 144D and that provides 24–hour supervision. 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.

(l) For the community alternatives for disabled individuals waiver, and nursing facility disabled waivers, county may use waiver funds for the cost of minor adaptations to a client's residence or vehicle without prior approval from the commissioner if there is no other source of funding and the adaptation:

(1) is necessary to avoid institutionalization;

(2) has no utility apart from the needs of the client; and

(3) meets the criteria in Minnesota Rules, part 9505.0210, items A and B.

For purposes of this subdivision, "residence" means the client's own home, the client's family residence, or a family foster home. For purposes of this subdivision, "vehicle" means the client's vehicle, the client's family vehicle, or the client's family foster home vehicle.

(m) The commissioner shall establish a maximum rate unit for baths provided by an adult day care provider that are not included in the provider's contractual daily or hourly rate. This maximum rate must equal the home health aide extended rate and shall be paid for baths provided to clients served under the elderly and disabled waivers.

[For text of subds 3a to 6, see M.S.1996]

Subd. 7. **Prepaid elderly waiver services.** An individual for whom a prepaid health plan is liable for nursing home services or elderly waiver services according to section 256B.69, subdivision 6a, is not eligible to receive county–administered elderly waiver services under this section.

History: *1997 c 113 s 18; 1997 c 203 art 4 s 40–43*

NOTE: Subdivision 7, as added by Laws 1997, chapter 203, article 4, section 43, is effective July 1, 1999. Laws 1997, chapter 203, article 4, section 74.

256B.0917 SENIORS' AGENDA FOR INDEPENDENT LIVING (SAIL) PROJECTS FOR A NEW LONG-TERM CARE STRATEGY.

[For text of subds 1 to 6, see M.S.1996]

Subd. 7. **Contract.** (a) The commissioner of human services shall execute a contract with Living at Home/Block Nurse Program, Inc. (LAH/BN, Inc.). The contract shall require LAH/BN, Inc. to:

(1) develop criteria for and award grants to establish community-based organizations that will implement living-at-home/block nurse programs throughout the state;

(2) award grants to enable current living-at-home/block nurse programs to continue to implement the combined living-at-home/block nurse program model;

(3) serve as a state technical assistance center to assist and coordinate the living-at-home/block nurse programs established; and

(4) manage contracts with individual living-at-home/block nurse programs.

(b) The contract shall be effective July 1, 1997, and section 16B.17 shall not apply.

Subd. 8. **Living-at-home/block nurse program grant.** (a) The organization awarded the contract under subdivision 7, shall develop and administer a grant program to establish or expand up to 27 community-based organizations that will implement living-at-home/block nurse programs that are designed to enable senior citizens to live as independently as possible in their homes and in their communities. At least one-half of the programs must be in counties outside the seven-county metropolitan area. Nonprofit organizations and units of local government are eligible to apply for grants to establish the community organizations that will implement living-at-home/block nurse programs. In awarding grants, the organization awarded the contract under subdivision 7 shall give preference to nonprofit organizations and units of local government from communities that:

(1) have high nursing home occupancy rates;

(2) have a shortage of health care professionals;

(3) are located in counties adjacent to, or are located in, counties with existing living-at-home/block nurse programs; and

(4) meet other criteria established by LAH/BN, Inc., in consultation with the commissioner.

(b) Grant applicants must also meet the following criteria:

(1) the local community demonstrates a readiness to establish a community model of care, including the formation of a board of directors, advisory committee, or similar group, of which at least two-thirds is comprised of community citizens interested in community-based care for older persons;

(2) the program has sponsorship by a credible, representative organization within the community;

(3) the program has defined specific geographic boundaries and defined its organization, staffing and coordination/delivery of services;

(4) the program demonstrates a team approach to coordination and care, ensuring that the older adult participants, their families, the formal and informal providers are all part of the effort to plan and provide services; and

(5) the program provides assurances that all community resources and funding will be coordinated and that other funding sources will be maximized, including a person's own resources.

(c) Grant applicants must provide a minimum of five percent of total estimated development costs from local community funding. Grants shall be awarded for four-year periods, and the base amount shall not exceed $80,000 per applicant for the grant period. The organization under contract may increase the grant amount for applicants from communities that have socioeconomic characteristics that indicate a higher level of need for assistance. Subject to the availability of funding, grants and grant renewals awarded or entered into on or after July 1, 1997, shall be renewed by LAH/BN, Inc. every four years, unless LAH/BN, Inc. determines that the grant recipient has not satisfactorily operated the living-at-home/block

nurse program in compliance with the requirements of paragraphs (b) and (d). Grants provided to living–at–home/block nurse programs under this paragraph may be used for both program development and the delivery of services.

(d) Each living–at–home/block nurse program shall be designed by representatives of the communities being served to ensure that the program addresses the specific needs of the community residents. The programs must be designed to:

(1) incorporate the basic community, organizational, and service delivery principles of the living–at–home/block nurse program model;

(2) provide senior citizens with registered nurse directed assessment, provision and coordination of health and personal care services on a sliding fee basis as an alternative to expensive nursing home care;

(3) provide information, support services, homemaking services, counseling, and training for the client and family caregivers;

(4) encourage the development and use of respite care, caregiver support, and in–home support programs, such as adult foster care and in–home adult day care;

(5) encourage neighborhood residents and local organizations to collaborate in meeting the needs of senior citizens in their communities;

(6) recruit, train, and direct the use of volunteers to provide informal services and other appropriate support to senior citizens and their caregivers; and

(7) provide coordination and management of formal and informal services to senior citizens and their families using less expensive alternatives.

[For text of subds 9 to 12, see M.S.1996]

History: *1997 c 203 art 4 s 44,45*

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

[For text of subds 1 to 5, see M.S.1996]

Subd. 6. **Rules.** The commissioner shall adopt rules to establish required controls, documentation, and reporting of services provided in order to assure proper administration of the approved waiver plan, and to establish policy and procedures to reduce duplicative efforts and unnecessary paperwork on the part of case managers.

[For text of subds 7 to 10, see M.S.1996]

History: *1997 c 7 art 5 s 30*

QUALITY ASSURANCE

256B.095 THREE–YEAR QUALITY ASSURANCE PILOT PROJECT ESTABLISHED.

Effective July 1, 1998, an alternative quality assurance licensing system pilot project for programs for persons with developmental disabilities is established in Dodge, Fillmore, Freeborn, Goodhue, Houston, Mower, Olmsted, Rice, Steele, Wabasha, and Winona counties for the purpose of improving the quality of services provided to persons with developmental disabilities. A county, at its option, may choose to have all programs for persons with developmental disabilities located within the county licensed under chapter 245A using standards determined under the alternative quality assurance licensing system pilot project or may continue regulation of these programs under the licensing system operated by the commissioner. The pilot project expires on June 30, 2001.

History: *1997 c 203 art 7 s 18*

256B.0951 QUALITY ASSURANCE COMMISSION.

Subdivision 1. **Membership.** The region 10 quality assurance commission is established. The commission consists of at least 13 but not more than 20 members as follows: at

least three but not more than five members representing advocacy organizations; at least three but not more than five members representing consumers, families, and their legal representatives; at least three but not more than five members representing service providers; and at least three but not more than five members representing counties. Initial membership of the commission shall be recruited and approved by the region 10 stakeholders group. Prior to approving the commission's membership, the stakeholders group shall provide to the commissioner a list of the membership in the stakeholders group, as of February 1, 1997, a brief summary of meetings held by the group since July 1, 1996, and copies of any materials prepared by the group for public distribution. The first commission shall establish membership guidelines for the transition and recruitment of membership for the commission's ongoing existence. Members of the commission who do not receive a salary or wages from an employer for time spent on commission duties may receive a per diem payment when performing commission duties and functions. All members may be reimbursed for expenses related to commission activities. Notwithstanding the provisions of section 15.059, subdivision 5, the commission expires on June 30, 2001.

Subd. 2. **Authority to hire staff.** The commission may hire staff to perform the duties assigned in this section.

Subd. 3. **Commission duties.** (a) By October 1, 1997, the commission, in cooperation with the commissioners of human services and health, shall do the following: (1) approve an alternative quality assurance licensing system based on the evaluation of outcomes; (2) approve measurable outcomes in the areas of health and safety, consumer evaluation, education and training, providers, and systems that shall be evaluated during the alternative licensing process; and (3) establish variable licensure periods not to exceed three years based on outcomes achieved. For purposes of this subdivision, "outcome" means the behavior, action, or status of a person that can be observed or measured and can be reliably and validly determined.

(b) By January 15, 1998, the commission shall approve, in cooperation with the commissioner of human services, a training program for members of the quality assurance teams established under section 256B.0952, subdivision 4.

Subd. 4. **Commission's authority to recommend variances of licensing standards.** The commission may recommend to the commissioners of human services and health variances from the standards governing licensure of programs for persons with developmental disabilities in order to improve the quality of services by implementing an alternative developmental disabilities licensing system if the commission determines that the alternative licensing system does not affect the health or safety of persons being served by the licensed program nor compromise the qualifications of staff to provide services.

Subd. 5. **Variance of certain standards prohibited.** The safety standards, rights, or procedural protections under sections 245.825; 245.91 to 245.97; 245A.04, subdivisions 3, 3a, 3b, and 3c; 245A.09, subdivision 2, paragraph (c), clauses (2) and (5); 245A.12; 245A.13; 252.41, subdivision 9; 256B.092, subdivisions 1b, clause (7), and 10; 626.556; 626.557, and procedures for the monitoring of psychotropic medications shall not be varied under the alternative licensing system pilot project. The commission may make recommendations to the commissioners of human services and health or to the legislature regarding alternatives to or modifications of the rules referenced in this subdivision.

Subd. 6. **Progress report.** The commission shall submit a progress report to the legislature on pilot project development by January 15, 1998. The report shall include recommendations on any legislative changes necessary to improve cooperation between the commission and the commissioners of human services and health.

History: *1997 c 203 art 7 s 19*

256B.0952 COUNTY DUTIES; QUALITY ASSURANCE TEAMS.

Subdivision 1. **Notification.** By January 15, 1998, each affected county shall notify the commission and the commissioners of human services and health as to whether it chooses to implement on July 1, 1998, the alternative licensing system for the pilot project. A county that does not implement the alternative licensing system on July 1, 1998, may give notice to the commission and the commissioners by January 15, 1999, or January 15, 2000, that it will

implement the alternative licensing system on the following July 1. A county that implements the alternative licensing system commits to participate until June 30, 2001.

Subd. 2. **Appointment of review council; duties of council.** A county or group of counties that chooses to participate in the alternative licensing system shall appoint a quality assurance review council comprised of advocates; consumers, families, and their legal representatives; providers; and county staff. The council shall:

(1) review summary reports from quality assurance team reviews and make recommendations to counties regarding program licensure;

(2) make recommendations to the commission regarding the alternative licensing system and quality assurance process; and

(3) resolve complaints between the quality assurance teams, counties, providers, and consumers, families, and their legal representatives.

Subd. 3. **Notice to commissioners.** The county, based on reports from quality assurance managers and recommendations from the quality assurance review council regarding the findings of quality assurance teams, shall notify the commissioners of human services and health regarding whether facilities, programs, or services have met the outcome standards for licensure and are eligible for payment.

Subd. 4. **Appointment of quality assurance manager.** (a) A county or group of counties that chooses to participate in the alternative licensing system shall designate a quality assurance manager and shall establish quality assurance teams in accordance with subdivision 5. The manager shall recruit, train, and assign duties to the quality assurance team members. In assigning team members to conduct the quality assurance process at a facility, program, or service, the manager shall take into account the size of the service provider, the number of services to be reviewed, the skills necessary for team members to complete the process, and other relevant factors. The manager shall ensure that no team member has a financial, personal, or family relationship with the facility, program, or service being reviewed or with any clients of the facility, program, or service.

(b) Quality assurance teams shall report the findings of their quality assurance reviews to the quality assurance manager. The quality assurance manager shall provide the report from the quality assurance team to the county and commissioners of human services and health and a summary of the report to the quality assurance review council.

Subd. 5. **Quality assurance teams.** Quality assurance teams shall be comprised of county staff; providers; consumers, families, and their legal representatives; members of advocacy organizations; and other involved community members. Team members must satisfactorily complete the training program approved by the commission and must demonstrate performance–based competency. Team members are not considered to be county employees for purposes of workers' compensation, unemployment compensation, or state retirement laws solely on the basis of participation on a quality assurance team. The county may pay a per diem to team members who do not receive a salary or wages from an employer for time spent on alternative quality assurance process matters. All team members may be reimbursed for expenses related to their participation in the alternative process.

Subd. 6. **Licensing functions.** Participating counties shall perform licensing functions and activities as delegated by the commissioner of human services in accordance with section 245A.16.

History: *1997 c 203 art 7 s 20*

256B.0953 QUALITY ASSURANCE PROCESS.

Subdivision 1. **Process components.** (a) The quality assurance licensing process consists of an evaluation by a quality assurance team of the facility, program, or service according to outcome–based measurements. The process must include an evaluation of a random sample of program consumers. The sample must be representative of each service provided. The sample size must be at least five percent of consumers but not less than three consumers.

(b) All consumers must be given the opportunity to be included in the quality assurance process in addition to those chosen for the random sample.

Subd. 2. **Licensure periods.** (a) In order to be licensed under the alternative quality assurance process, a facility, program, or service must satisfy the health and safety outcomes approved for the pilot project.

(b) Licensure shall be approved for periods of one to three years for a facility, program, or service that satisfies the requirements of paragraph (a) and achieves the outcome measurements in the categories of consumer evaluation, education and training, providers, and systems.

Subd. 3. **Appeals process.** A facility, program, or service may contest a licensing decision of the quality assurance team as permitted under chapter 245A.

History: *1997 c 203 art 7 s 21*

256B.0954 CERTAIN PERSONS DEFINED AS MANDATED REPORTERS.

Members of the quality assurance commission established under section 256B.0951, members of quality assurance review councils established under section 256B.0952, quality assurance managers appointed under section 256B.0952, and members of quality assurance teams established under section 256B.0952 are mandated reporters as that term is defined in sections 626.556, subdivision 3, and 626.5572, subdivision 16.

History: *1997 c 203 art 7 s 22*

256B.0955 DUTIES OF THE COMMISSIONER OF HUMAN SERVICES.

(a) Effective July 1, 1998, the commissioner of human services shall delegate authority to perform licensing functions and activities, in accordance with section 245A.16, to counties participating in the alternative licensing system. The commissioner shall not license or reimburse a facility, program, or service for persons with developmental disabilities in a county that participates in the alternative licensing system if the commissioner has received from the appropriate county notification that the facility, program, or service has been reviewed by a quality assurance team and has failed to qualify for licensure.

(b) The commissioner may conduct random licensing inspections based on outcomes adopted under section 256B.0951 at facilities, programs, and services governed by the alternative licensing system. The role of such random inspections shall be to verify that the alternative licensing system protects the safety and well–being of consumers and maintains the availability of high–quality services for persons with developmental disabilities.

(c) The commissioner shall provide technical assistance and support or training to the alternative licensing system pilot project.

(d) The commissioner and the commission shall establish an ongoing evaluation process for the alternative licensing system.

(e) The commissioner shall contract with an independent entity to conduct a financial review of the alternative licensing system, including an evaluation of possible budgetary savings within the department of human services and the department of health as a result of implementation of the alternative quality assurance licensing system. This review must be completed by December 15, 2000.

(f) The commissioner and the commission shall submit a report to the legislature by January 15, 2001, on the results of the evaluation process of the alternative licensing system, a summary of the results of the independent financial review, and a recommendation on whether the pilot project should be extended beyond June 30, 2001.

History: *1997 c 203 art 7 s 23*

256B.17 TRANSFERS OF PROPERTY.

Subdivision 1. [Repealed, 1997 c 107 s 19]

Subd. 2. [Repealed, 1997 c 107 s 19]

Subd. 3. [Repealed, 1997 c 107 s 19]

Subd. 4. [Repealed, 1997 c 107 s 19]

Subd. 5. [Repealed, 1997 c 107 s 19]

Subd. 6. [Repealed, 1997 c 107 s 19]

Subd. 7. **Exception for asset transfers.** An institutionalized spouse, institutionalized before October 1, 1989, for a continuous period, who applies for medical assistance on or after July 1, 1983, may transfer liquid assets to a noninstitutionalized spouse if all of the following conditions apply:

(a) The noninstitutionalized spouse is not applying for or receiving assistance;

(b) Either (1) the noninstitutionalized spouse has less than $10,000 in liquid assets, including assets singly owned and 50 percent of assets owned jointly with the institutionalized spouse; or (2) the noninstitutionalized spouse has less than 50 percent of the total value of nonexempt assets owned by both parties, jointly or individually;

(c) The amount transferred, together with the noninstitutionalized spouse's own assets, totals no more than one–half of the total value of the liquid assets of the parties or $10,000 in liquid assets, whichever is greater; and

(d) The transfer may be effected only once, at the time of initial medical assistance application.

Subd. 8. [Repealed, 1997 c 107 s 19]

History: *1997 c 107 s 7*

256B.19 DIVISION OF COST.

[For text of subds 1 to 2, see M.S.1996]

Subd. 2a. **Division of costs.** The county shall ensure that only the least costly, most appropriate transportation and travel expenses are used. The state may enter into volume purchase contracts, or use a competitive bidding process, whenever feasible, to minimize the costs of transportation services. If the state has entered into a volume purchase contract or used the competitive bidding procedures of chapter 16B to arrange for transportation services, the county may be required to use such arrangements.

[For text of subds 2b to 3, see M.S.1996]

History: *1997 c 203 art 11 s 7*

256B.37 PRIVATE INSURANCE POLICIES, CAUSES OF ACTION.

Subdivision 1. **Subrogation.** Upon furnishing medical assistance to any person who has private accident or health care coverage, or receives or has a right to receive health or medical care from any type of organization or entity, or has a cause of action arising out of an occurrence that necessitated the payment of medical assistance, the state agency or the state agency's agent shall be subrogated, to the extent of the cost of medical care furnished, to any rights the person may have under the terms of the coverage, or against the organization or entity providing or liable to provide health or medical care, or under the cause of action.

The right of subrogation created in this section includes all portions of the cause of action, notwithstanding any settlement allocation or apportionment that purports to dispose of portions of the cause of action not subject to subrogation.

[For text of subds 2 to 6, see M.S.1996]

History: *1997 c 217 art 2 s 8*

256B.421 DEFINITIONS.

Subdivision 1. **Scope.** For the purposes of this section and sections 256B.41, 256B.411, 256B.431, 256B.432, 256B.433, 256B.434, 256B.47, 256B.48, 256B.50, and 256B.502, the following terms and phrases shall have the meaning given to them.

[For text of subds 2 to 16, see M.S.1996]

History: *1997 c 203 art 3 s 6*

256B.431 RATE DETERMINATION.

[For text of subds 1 to 2d, see M.S.1996]

Subd. 2e. **Contracts for services for ventilator dependent persons.** The commissioner may contract with a nursing facility eligible to receive medical assistance payments to provide services to a ventilator dependent person identified by the commissioner according to criteria developed by the commissioner, including:

(1) nursing facility care has been recommended for the person by a preadmission screening team;

(2) the person has been assessed at case mix classification K;

(3) the person has been hospitalized for at least six months and no longer requires inpatient acute care hospital services; and

(4) the commissioner has determined that necessary services for the person cannot be provided under existing nursing facility rates.

The commissioner may issue a request for proposals to provide services to a ventilator dependent person to nursing facilities eligible to receive medical assistance payments and shall select nursing facilities from among respondents according to criteria developed by the commissioner, including:

(1) the cost–effectiveness and appropriateness of services;

(2) the nursing facility's compliance with federal and state licensing and certification standards; and

(3) the proximity of the nursing facility to a ventilator–dependent person identified by the commissioner who requires nursing facility placement.

The commissioner may negotiate an adjustment to the operating cost payment rate for a nursing facility selected by the commissioner from among respondents to the request for proposals. The negotiated adjustment must reflect only the actual additional cost of meeting the specialized care needs of a ventilator–dependent person identified by the commissioner for whom necessary services cannot be provided under existing nursing facility rates and which are not otherwise covered under Minnesota Rules, parts 9549.0010 to 9549.0080 or 9505.0170 to 9505.0475. The negotiated payment rate must not exceed 200 percent of the highest multiple bedroom payment rate for a Minnesota nursing facility, as initially established by the commissioner for the rate year for case mix classification K. The negotiated adjustment shall not affect the payment rate charged to private paying residents under the provisions of section 256B.48, subdivision 1.

[For text of subds 2f to 3e, see M.S.1996]

Subd. 3f. **Property costs after July 1, 1988.** (a) **Investment per bed limit.** For the rate year beginning July 1, 1988, the replacement–cost–new per bed limit must be $32,571 per licensed bed in multiple bedrooms and $48,857 per licensed bed in a single bedroom. For the rate year beginning July 1, 1989, the replacement–cost–new per bed limit for a single bedroom must be $49,907 adjusted according to Minnesota Rules, part 9549.0060, subpart 4, item A, subitem (1). Beginning January 1, 1990, the replacement–cost–new per bed limits must be adjusted annually as specified in Minnesota Rules, part 9549.0060, subpart 4, item A, subitem (1). Beginning January 1, 1991, the replacement–cost–new per bed limits will be adjusted annually as specified in Minnesota Rules, part 9549.0060, subpart 4, item A, subitem (1), except that the index utilized will be the Bureau of the Census: Composite fixed–weighted price index as published in the C30 Report, Value of New Construction Put in Place.

(b) **Rental factor.** For the rate year beginning July 1, 1988, the commissioner shall increase the rental factor as established in Minnesota Rules, part 9549.0060, subpart 8, item A, by 6.2 percent rounded to the nearest 100th percent for the purpose of reimbursing nursing facilities for soft costs and entrepreneurial profits not included in the cost valuation services used by the state's contracted appraisers. For rate years beginning on or after July 1, 1989, the rental factor is the amount determined under this paragraph for the rate year beginning July 1, 1988.

(c) **Occupancy factor.** For rate years beginning on or after July 1, 1988, in order to determine property–related payment rates under Minnesota Rules, part 9549.0060, for all nursing facilities except those whose average length of stay in a skilled level of care within a nursing facility is 180 days or less, the commissioner shall use 95 percent of capacity days. For a nursing facility whose average length of stay in a skilled level of care within a nursing facility is 180 days or less, the commissioner shall use the greater of resident days or 80 percent of capacity days but in no event shall the divisor exceed 95 percent of capacity days.

(d) **Equipment allowance.** For rate years beginning on July 1, 1988, and July 1, 1989, the commissioner shall add ten cents per resident per day to each nursing facility's property–related payment rate. The ten–cent property–related payment rate increase is not cumulative from rate year to rate year. For the rate year beginning July 1, 1990, the commissioner shall increase each nursing facility's equipment allowance as established in Minnesota Rules, part 9549.0060, subpart 10, by ten cents per resident per day. For rate years beginning on or after July 1, 1991, the adjusted equipment allowance must be adjusted annually for inflation as in Minnesota Rules, part 9549.0060, subpart 10, item E. For the rate period beginning October 1, 1992, the equipment allowance for each nursing facility shall be increased by 28 percent. For rate years beginning after June 30, 1993, the allowance must be adjusted annually for inflation.

(e) **Post chapter 199 related–organization debts and interest expense.** For rate years beginning on or after July 1, 1990, Minnesota Rules, part 9549.0060, subpart 5, item E, shall not apply to outstanding related organization debt incurred prior to May 23, 1983, provided that the debt was an allowable debt under Minnesota Rules, parts 9510.0010 to 9510.0480, the debt is subject to repayment through annual principal payments, and the nursing facility demonstrates to the commissioner's satisfaction that the interest rate on the debt was less than market interest rates for similar arms–length transactions at the time the debt was incurred. If the debt was incurred due to a sale between family members, the nursing facility must also demonstrate that the seller no longer participates in the management or operation of the nursing facility. Debts meeting the conditions of this paragraph are subject to all other provisions of Minnesota Rules, parts 9549.0010 to 9549.0080.

(f) **Building capital allowance for nursing facilities with operating leases.** For rate years beginning on or after July 1, 1990, a nursing facility with operating lease costs incurred for the nursing facility's buildings shall receive its building capital allowance computed in accordance with Minnesota Rules, part 9549.0060, subpart 8.

[For text of subds 3g to 17, see M.S.1996]

Subd. 18. **Appraisals; updating appraisals, additions, and replacements.** (a) Notwithstanding Minnesota Rules, part 9549.0060, subparts 1 to 3, the appraised value, routine updating of the appraised value, and special reappraisals are subject to this subdivision.

(1) For rate years beginning after June 30, 1993, the commissioner shall permit a nursing facility to appeal its appraisal. Any reappraisals conducted in connection with that appeal must utilize the comparative–unit method as described in the Marshall Valuation Service published by Marshall–Swift in establishing the nursing facility's depreciated replacement cost.

Nursing facilities electing to appeal their appraised value shall file written notice of appeal with the commissioner of human services before December 30, 1992. The cost of the reappraisal, if any, shall be considered an allowable cost under Minnesota Rules, parts 9549.0040, subpart 9, and 9549.0061.

(2) The redetermination of a nursing facility's appraised value under this paragraph shall have no impact on the rental payment rate determined under subdivision 13 but shall only be used for calculating the nursing facility's rental rate under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section for rate years beginning after June 30, 1993.

(3) For all rate years after June 30, 1993, the commissioner shall no longer conduct any appraisals under Minnesota Rules, part 9549.0060, for the purpose of determining property–related payment rates.

(b) Notwithstanding Minnesota Rules, part 9549.0060, subpart 2, for rate years beginning after June 30, 1993, the commissioner shall routinely update the appraised value of each

nursing facility by adding the cost of capital asset acquisitions to its allowable appraised value.

The commissioner shall also annually index each nursing facility's allowable appraised value by the inflation index referenced in subdivision 3f, paragraph (a), for the purpose of computing the nursing facility's annual rental rate. In annually adjusting the nursing facility's appraised value, the commissioner must not include the historical cost of capital assets acquired during the reporting year in the nursing facility's appraised value.

In addition, the nursing facility's appraised value must be reduced by the historical cost of capital asset disposals or applicable credits such as public grants and insurance proceeds. Capital asset additions and disposals must be reported on the nursing facility's annual cost report in the reporting year of acquisition or disposal. The incremental increase in the nursing facility's rental rate resulting from this annual adjustment as determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section shall be added to the nursing facility's property–related payment rate for the rate year following the reporting year.

[For text of subds 19 to 24, see M.S.1996]

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, using 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 estab-

lished 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 Re-

sources 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).

(h)(1) A nursing facility licensed for 302 beds on September 30, 1993, that was approved under the moratorium exception process in section 144A.073 for a partial replacement, and completed the replacement project in December 1994, is exempt from paragraphs (b) to (d) for rate years beginning on or after July 1, 1995.

(2) For the rate year beginning July 1, 1997, after computing this nursing facility's payment rate according to section 256B.434, the commissioner shall make a one–year rate adjustment of $8.62 to the facility's contract payment rate for the rate effect of operating cost changes associated with the facility's 1994 downsizing project.

(3) For rate years beginning on or after July 1, 1997, the commissioner shall add 35 cents to the facility's base property related payment rate for the rate effect of reducing its licensed capacity to 290 beds from 302 beds and shall add 83 cents to the facility's real estate tax and special assessment payment rate for payments in lieu of real estate taxes. The adjustments in this clause shall remain in effect for the duration of the facility's contract under section 256B.434.

(i) Notwithstanding Laws 1996, chapter 451, article 3, section 11, paragraph (h), for the rate years beginning on July 1, 1996, July 1, 1997, and July 1, 1998, a nursing facility licensed for 40 beds effective May 1, 1992, with a subsequent increase of 20 Medicare/Medicaid certified beds, effective January 26, 1993, in accordance with an increase in licensure is exempt from paragraphs (b) to (d).

Subd. 26. **Changes to nursing facility reimbursement beginning July 1, 1997.** The nursing facility reimbursement changes in paragraphs (a) to (f) shall apply in the sequence specified in Minnesota Rules, parts 9549.0010 to 9549.0080, and this section, beginning July 1, 1997.

(a) For rate years beginning on or after July 1, 1997, the commissioner shall limit a nursing facility's allowable operating per diem for each case mix category for each rate year. The commissioner shall group nursing facilities into two groups, freestanding and nonfreestanding, within each geographic group, using 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:

(1) is at or 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 diem as specified in Laws 1996, chapter 451, article 3, section 11, paragraph (h), plus the inflation factor as established in paragraph (d), clause (2), increased by two percentage points, or the current reporting year's corresponding allowable operating cost per diem; or

(2) is above 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 diem as specified in Laws 1996, chapter 451, article 3, section 11, paragraph (h), plus the inflation factor as established in paragraph (d), clause (2), increased by one percentage point, or the current reporting year's corresponding allowable operating cost per diem.

(b) For rate years beginning on or after July 1, 1997, the commissioner shall limit the allowable operating cost per diem for high cost nursing facilities. After application of the limits in paragraph (a) to each nursing facility's operating cost per diem, 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 diem 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 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 exceeds 1.0 standard deviation above the median, the commissioner shall reduce their allowable operating cost per diem 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 diem by two percent. However, in no case shall a nursing facility's operating cost per diem be reduced below its grouping's limit established at 0.5 standard deviations above the median.

(c) For rate years beginning on or after July 1, 1997, 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).

(d) For rate years beginning on or after July 1, 1997, the forecasted price index for a nursing facility's allowable operating cost per diem shall be determined under clauses (1) and (2) using the change in the Consumer Price Index–All Items (United States city average) (CPI–U) as forecasted by Data Resources, Inc. The commissioner shall use the indices as forecasted in the fourth quarter of the calendar year preceding the rate year, subject to subdivision 2l, paragraph (c).

(1) The CPI–U forecasted index for allowable operating cost per diem 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) For rate years beginning on or after July 1, 1997, 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.

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

(f) For rate years beginning on or after July 1, 1997, the total operating cost payment rates for a nursing facility shall be the greater of the total operating cost payment rates determined under this section or the total operating cost payment rates in effect on June 30, 1997, subject to rate adjustments due to field audit or rate appeal resolution. This provision shall not apply to subsequent field audit adjustments of the nursing facility's operating cost rates for rate years beginning on or after July 1, 1997.

(g) For the rate years beginning on July 1, 1997, and July 1, 1998, a nursing facility licensed for 40 beds effective May 1, 1992, with a subsequent increase of 20 Medicare/Medicaid certified beds, effective January 26, 1993, in accordance with an increase in licensure is exempt from paragraphs (a) and (b).

(h) For a nursing facility whose construction project was authorized according to section 144A.073, subdivision 5, paragraph (g), the operating cost payment rates for the third location shall be determined based on Minnesota Rules, part 9549.0057. Paragraphs (a) and (b) shall not apply until the second rate year after the settle–up cost report is filed. Notwithstanding subdivision 2b, paragraph (g), real estate taxes and special assessments payable by the third location, a 501(c)(3) nonprofit corporation, shall be included in the payment rates determined under this subdivision for all subsequent rate years.

(i) For the rate year beginning July 1, 1997, the commissioner shall compute the payment rate for a nursing facility licensed for 94 beds on September 30, 1996, that applied in October 1993 for approval of a total replacement under the moratorium exception process in section 144A.073, and completed the approved replacement in June 1995, with other operating cost spend–up limit under paragraph (a), increased by $3.98, and after computing the facility's payment rate according to this section, the commissioner shall make a one–year positive rate adjustment of $3.19 for operating costs related to the newly constructed total replacement, without application of paragraphs (a) and (b). The facility's per diem, before the $3.19 adjustment, shall be used as the prior reporting year's allowable operating cost per diem for payment rate calculation for the rate year beginning July 1, 1998. A facility described in this paragraph is exempt from paragraph (b) for the rate years beginning July 1, 1997, and July 1, 1998.

(j) For the purpose of applying the limit stated in paragraph (a), a nursing facility in Kandiyohi county licensed for 86 beds that was granted hospital–attached status on December 1, 1994, shall have the prior year's allowable care–related per diem increased by $3.207 and the prior year's other operating cost per diem increased by $4.777 before adding the inflation in paragraph (d), clause (2), for the rate year beginning on July 1, 1997.

(k) For the purpose of applying the limit stated in paragraph (a), a 117 bed nursing facility located in Pine county shall have the prior year's allowable other operating cost per diem increased by $1.50 before adding the inflation in paragraph (d), clause (2), for the rate year beginning on July 1, 1997.

(l) For the purpose of applying the limit under paragraph (a), a nursing facility in Hibbing licensed for 192 beds shall have the prior year's allowable other operating cost per diem increased by $2.67 before adding the inflation in paragraph (d), clause (2), for the rate year beginning July 1, 1997.

History: *1997 c 2 s 10; 1997 c 107 s 8; 1997 c 187 art 3 s 29; 1997 c 203 art 3 s 7,8; art 4 s 46*

256B.433 ANCILLARY SERVICES.

[For text of subds 1 to 3, see M.S.1996]

Subd. 3a. **Exemption from requirement for separate therapy billing.** The provisions of subdivision 3 do not apply to nursing facilities that are reimbursed according to the provisions of section 256B.431 and are located in a county participating in the prepaid medical assistance program.

History: *1997 c 203 art 3 s 9*

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

[For text of subd 1, see M.S.1996]

Subd. 2. **Requests for proposals.** (a) At least twice annually the commissioner shall publish in the State Register a request for proposals to provide nursing facility services according to this section. The commissioner must respond to all proposals in a timely manner.

(b) The commissioner may reject any proposal if, in the judgment of the commissioner, a contract with a particular facility is not in the best interests of the residents of the facility or the state of Minnesota. The commissioner may accept up to the number of proposals that can be adequately supported with available state resources, as determined by the commissioner. The commissioner may accept proposals from a single nursing facility or from a group of facilities through a managing entity. The commissioner shall seek to ensure that nursing facilities under contract are located in all geographic areas of the state.

(c) In issuing the request for proposals, the commissioner may develop reasonable requirements which, in the judgment of the commissioner, are necessary to protect residents or ensure that the contractual alternative payment demonstration project furthers the interest of the state of Minnesota. The request for proposals may include, but need not be limited to, the following:

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

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

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

(4) a requirement to agree to participate in a project to develop data collection systems and outcome–based standards. Among other requirements specified by the commissioner, each facility entering into a contract may be required to pay an annual fee. Revenue generated from the fees is appropriated to the commissioner and must be used to contract with a qualified consultant or contractor to develop data collection systems and outcome–based contracting standards;

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

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

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

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

(1) the facility's history of compliance with federal and state laws and rules, except that a facility deemed to be in substantial compliance with federal and state laws and rules is eligible to respond to a request for proposal. A facility's compliance history shall not be the sole determining factor in situations where the facility has been sold and the new owners have submitted a proposal;

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

(3) financial history and solvency; and

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

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

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

(b) All contracts entered into under this section are for a term of one year. Either party may terminate a contract at any time without cause by providing 30 calendar days advance written notice to the other party. The decision to terminate a contract is not appealable. If neither party provides written notice of termination the contract shall be renegotiated for additional one–year terms, for up to a total of four consecutive one–year terms. The provisions of the contract shall be renegotiated annually by the parties prior to the expiration date of the contract. The parties may voluntarily renegotiate the terms of the contract at any time by mutual agreement.

(c) If a nursing facility fails to comply with the terms of a contract, the commissioner shall provide reasonable notice regarding the breach of contract and a reasonable opportunity for the facility to come into compliance. If the facility fails to come into compliance or to remain in compliance, the commissioner may terminate the contract. If a contract is terminated, the contract payment remains in effect for the remainder of the rate year in which the contract was terminated, but in all other respects the provisions of this section do not apply to that facility effective the date the contract is terminated. The contract shall contain a provision governing the transition back to the cost–based reimbursement system established under section 256B.431, 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 shall develop additional incentive–based payments of up to five percent above the standard contract rate for achieving outcomes specified in each contract. The specified facility–specific outcomes must be measurable and approved 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 proposed by a nursing facility that the commissioner finds desirable.

[For text of subds 5 to 8, see M.S.1996]

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

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

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

(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.

(e) A facility that is under contract with the commissioner under this section shall be allowed to change therapy arrangements from an unrelated vendor to a related vendor during the term of the contract. The commissioner may develop reasonable requirements designed to prevent an increase in therapy utilization for residents enrolled in the medical assistance program.

[For text of subd 11, see M.S.1996]

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 require-

ments of contracts the commissioner is exempt from the rulemaking requirements in chapter 14 until December 31, 2000.

[For text of subds 13 to 17, see M.S.1996]

History: *1997 c 187 art 4 s 8; 1997 c 203 art 3 s 10–12; art 9 s 11,12*

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 average monthly limit for the cost of home and community–based services to a community alternative care waiver client, determined on a 12–month basis, shall not exceed the statewide average medical assistance adjusted base–year operating cost for nursing and accommodation services under sections 256.9685 to 256.969 for the diagnostic category to which the waiver client would be assigned except the admission and outlier rates shall be converted to an overall per diem. The average monthly limit for the cost of services to a traumatic brain injury neurobehavioral hospital waiver client, determined on a 12–month basis, shall not exceed the statewide average medical assistance adjusted base–year operating cost for nursing and accommodation services of neurobehavioral rehabilitation programs in Medicare designated long–term hospitals under sections 256.9685 to 256.969. The following costs must be included in determining the total average monthly costs for a waiver client:

(1) cost of all waivered services; and

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

The commissioner of human services shall seek federal waivers as necessary to implement the average monthly limit. 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.

Subd. 2. **Rules.** The commissioner of human services may adopt rules as necessary to implement subdivision 1.

[For text of subds 3 to 8, see M.S.1996]

Subd. 9. **Prevocational and supported employment services.** The commissioner shall seek to amend the community alternatives for disabled individuals waivers and the traumatic brain injury waivers to include prevocational and supported employment services.

History: *1997 c 7 art 5 s 31; 1997 c 203 art 4 s 47; art 7 s 24*

256B.50 APPEALS.

Subdivision 1. **Scope.** A provider may appeal from a determination of a payment rate established pursuant to this chapter and reimbursement rules of the commissioner if the appeal, if successful, would result in a change to the provider's payment rate or to the calculation of maximum charges to therapy vendors as provided by section 256B.433, subdivision 3. Appeals must be filed in accordance with procedures in this section. This section does not apply to a request from a resident or long–term care facility for reconsideration of the classification of a resident under section 144.0722 or 144.0723.

[For text of subd 1a, see M.S.1996]

Subd. 1b. **Filing an appeal.** To appeal, the provider shall file with the commissioner a written notice of appeal; the appeal must be postmarked or received by the commissioner within 60 days of the date the determination of the payment rate was mailed or personally received by a provider, whichever is earlier. The notice of appeal must specify each disputed item; the reason for the dispute; the total dollar amount in dispute for each separate disallowance, allocation, or adjustment of each cost item or part of a cost item; the computation that the provider believes is correct; the authority in statute or rule upon which the provider relies for each disputed item; the name and address of the person or firm with whom contacts may be made regarding the appeal; and other information required by the commissioner.

Subd. 1c. **Contested case procedures appeals review process.** (a) Effective for desk audit appeals for rate years beginning on or after July 1, 1997, and for field audit appeals filed on or after that date, the commissioner shall review appeals and issue a written appeal determination on each appealed item within one year of the due date of the appeal. Upon mutual agreement, the commissioner and the provider may extend the time for issuing a determination for a specified period. The commissioner shall notify the provider by first class mail of the appeal determination. The appeal determination takes effect 30 days following the date of issuance specified in the determination.

(b) In reviewing the appeal, the commissioner may request additional written or oral information from the provider. The provider has the right to present information by telephone, in writing, or in person concerning the appeal to the commissioner prior to the issuance of the appeal determination within six months of the date the appeal was received by the commissioner. Written requests for conferences must be submitted separately from the appeal letter. Statements made during the review process are not admissible in a contested case hearing absent an express stipulation by the parties to the contested case.

(c) For an appeal item on which the provider disagrees with the appeal determination, the provider may file with the commissioner a written demand for a contested case hearing to determine the proper resolution of specified appeal items. The demand must be postmarked or received by the commissioner within 30 days of the date of issuance specified in the determination. A contested case demand for an appeal item nullifies the written appeal determination issued by the commissioner for that appeal item. The commissioner shall refer any contested case demand to the office of the attorney general.

(d) A contested case hearing must be heard by an administrative law judge according to sections 14.48 to 14.56. In any proceeding under this section, the appealing party must demonstrate by a preponderance of the evidence that the determination of a payment rate is incorrect.

(e) Regardless of any rate appeal, the rate established must be the rate paid and must remain in effect until final resolution of the appeal or subsequent desk or field audit adjustment.

(f) To challenge the validity of rules established by the commissioner pursuant to this section and sections 256B.41, 256B.421, 256B.431, 256B.47, 256B.48, 256B.501, and 256B.502, a provider shall comply with section 14.44.

(g) The commissioner has discretion to issue to the provider a proposed resolution for specified appeal items upon a request from the provider filed separately from the notice of appeal. The proposed resolution is final upon written acceptance by the provider within 30 days of the date the proposed resolution was mailed to or personally received by the provider, whichever is earlier.

(h) The commissioner may use the procedures described in this subdivision to resolve appeals filed prior to July 1, 1997.

Subd. 1d. [Repealed, 1997 c 107 s 19]

Subd. 1e. **Attorney's fees and costs.** (a) Notwithstanding section 15.472, paragraph (a), for an issue appealed under subdivision 1, the prevailing party in a contested case proceeding or, if appealed, in subsequent judicial review, must be awarded reasonable attorney's fees and costs incurred in litigating the appeal, if the prevailing party shows that the position of the opposing party was not substantially justified. The procedures for awarding fees and costs set forth in section 15.474 must be followed in determining the prevailing party's fees and costs except as otherwise provided in this subdivision. For purposes of this subdivision, "costs" means subpoena fees and mileage, transcript costs, court reporter fees, witness fees, postage and delivery costs, photocopying and printing costs, amounts charged the commissioner by the office of administrative hearings, and direct administrative costs of the department; and "substantially justified" means that a position had a reasonable basis in law and fact, based on the totality of the circumstances prior to and during the contested case proceeding and subsequent review.

(b) When an award is made to the department under this subdivision, attorney fees must be calculated at the cost to the department. When an award is made to a provider under this subdivision, attorney fees must be calculated at the rate charged to the provider except that attorney fees awarded must be the lesser of the attorney's normal hourly fee or $100 per hour.

(c) In contested case proceedings involving more than one issue, the administrative law judge shall determine what portion of each party's attorney fees and costs is related to the issue or issues on which it prevailed and for which it is entitled to an award. In making that determination, the administrative law judge shall consider the amount of time spent on each issue, the precedential value of the issue, the complexity of the issue, and other factors deemed appropriate by the administrative law judge.

(d) When the department prevails on an issue involving more than one provider, the administrative law judge shall allocate the total amount of any award for attorney fees and costs among the providers. In determining the allocation, the administrative law judge shall consider each provider's monetary interest in the issue and other factors deemed appropriate by the administrative law judge.

(e) Attorney fees and costs awarded to the department for proceedings under this subdivision must not be reported or treated as allowable costs on the provider's cost report.

(f) Fees and costs awarded to a provider for proceedings under this subdivision must be reimbursed to them by reporting the amount of fees and costs awarded as allowable costs on the provider's cost report for the reporting year in which they were awarded. Fees and costs reported pursuant to this subdivision must be included in the general and administrative cost category but are not subject to categorical or overall cost limitations established in rule or statute.

(g) If the provider fails to pay the awarded attorney fees and costs within 120 days of the final decision on the award of attorney fees and costs, the department may collect the amount due through any method available to it for the collection of medical assistance overpayments to providers. Interest charges must be assessed on balances outstanding after 120 days of the final decision on the award of attorney fees and costs. The annual interest rate charged must be the rate charged by the commissioner of revenue for late payment of taxes that is in effect on the 121st day after the final decision on the award of attorney fees and costs.

(h) Amounts collected by the commissioner pursuant to this subdivision must be deemed to be recoveries pursuant to section 256.01, subdivision 2, clause (15).

(i) This subdivision applies to all contested case proceedings set on for hearing by the commissioner on or after April 29, 1988, regardless of the date the appeal was filed.

[For text of subd 1f, see M.S.1996]

Subd. 1g. [Repealed, 1997 c 107 s 19]

Subd. 1h. [Repealed, 1997 c 107 s 19]

Subd. 2. [Repealed, 1997 c 107 s 19]

[For text of subd 3, see M.S.1996]

History: *1997 c 107 s 9–12*

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

[For text of subds 1 to 5b, see M.S.1996]

Subd. 5c. [Repealed, 1997 c 203 art 7 s 29]

[For text of subds 5d to 8a, see M.S.1996]

Subd. 10. **Rules.** To implement this section, the commissioner shall promulgate rules in accordance with chapter 14.

[For text of subds 11 and 12, see M.S.1996]

History: *1997 c 187 art 5 s 28*

256B.502 RULES.

The commissioners of health and human services shall promulgate rules necessary to implement Laws 1983, chapter 199.

History: *1997 c 187 art 5 s 29*

256B.503 RULES.

To implement Laws 1983, chapter 312, article 9, sections 1 to 7, the commissioner shall promulgate rules. Rules adopted to implement Laws 1983, chapter 312, article 9, section 5, must (a) be in accord with the provisions of Minnesota Statutes, chapter 256E, (b) set standards for case management which include, encourage and enable flexible administration, (c) require the county boards to develop individualized procedures governing case management activities, (d) consider criteria promulgated under section 256B.092, subdivision 3, and the federal waiver plan, (e) identify cost implications to the state and to county boards, and (f) require the screening teams to make recommendations to the county case manager for development of the individual service plan.

The commissioner shall adopt rules to implement this section by July 1, 1986.

History: *1997 c 187 art 5 s 30*

256B.69 PREPAYMENT DEMONSTRATION PROJECT.

[For text of subd 1, see M.S.1996]

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

(a) "Commissioner" means the commissioner of human services. For the remainder of this section, the commissioner's responsibilities for methods and policies for implementing the project will be proposed by the project advisory committees and approved by the commissioner.

(b) "Demonstration provider" means a health maintenance organization or community integrated service network authorized and operating under chapter 62D or 62N that participates in the demonstration project according to criteria, standards, methods, and other requirements established for the project and approved by the commissioner. Notwithstanding

the above, Itasca county may continue to participate as a demonstration provider until July 1, 2000.

(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.1996]

Subd. 3a. **County authority.** (a) 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. The county board or a single entity representing a group of county boards and the commissioner shall mutually select health plans for participation at the time of initial implementation of the prepaid medical assistance program in that county or group of counties and at the time of contract renewal. The commissioner shall also seek input for contract requirements from the county or single entity representing a group of county boards at each contract renewal and incorporate those recommendations into the contract negotiation process. The commissioner, in conjunction with the county board, shall actively seek to develop a mutually agreeable timetable prior to the development of the request for proposal, but counties must agree to initial enrollment beginning on or before January 1, 1999, in either the prepaid medical assistance and general assistance medical care programs or county–based purchasing under section 256B.692. At least 90 days before enrollment in the medical assistance and general assistance medical care prepaid programs begins in a county in which the prepaid programs have not been established, the commissioner shall provide a report to the chairs of senate and house committees having jurisdiction over state health care programs which verifies that the commissioner complied with the requirements for county involvement that are specified in this subdivision.

(b) The commissioner shall seek a federal waiver to allow a fee–for–service plan option to MinnesotaCare enrollees. The commissioner shall develop an increase of the premium fees required under section 256L.06 up to 20 percent of the premium fees for the enrollees who elect the fee–for–service option. Prior to implementation, the commissioner shall sub-

mit this fee schedule to the chair and ranking minority member of the senate health care committee, the senate health care and family services funding division, the house of representatives health and human services committee, and the house of representatives health and human services finance division.

(c) At the option of the county board, the board may develop contract requirements related to the achievement of local public health goals to meet the health needs of medical assistance and general assistance medical care enrollees. These requirements must be reasonably related to the performance of health plan functions and within the scope of the medical assistance and general assistance medical care benefit sets. If the county board and the commissioner mutually agree to such requirements, the department shall include such requirements in all health plan contracts governing the prepaid medical assistance and general assistance medical care programs in that county at initial implementation of the program in that county and at the time of contract renewal. The county board may participate in the enforcement of the contract provisions related to local public health goals.

(d) For counties in which prepaid medical assistance and general assistance medical care programs have not been established, the commissioner shall not implement those programs if a county board submits acceptable and timely preliminary and final proposals under section 256B.692, until county–based purchasing is no longer operational in that county. For counties in which prepaid medical assistance and general assistance medical care programs are in existence on or after September 1, 1997, the commissioner must terminate contracts with health plans according to section 256B.692, subdivision 5, if the county board submits and the commissioner accepts preliminary and final proposals according to that subdivision. The commissioner is not required to terminate contracts that begin on or after September 1, 1997, according to section 256B.692 until two years have elapsed from the date of initial enrollment.

(e) In the event that a county board or a single entity representing a group of county boards and the commissioner cannot reach agreement regarding: (i) the selection of participating health plans in that county; (ii) contract requirements; or (iii) implementation and enforcement of county requirements including provisions regarding local public health goals, the commissioner shall resolve all disputes after taking into account the recommendations of a three–person mediation panel. The panel shall be composed of one designee of the president of the association of Minnesota counties, one designee of the commissioner of human services, and one designee of the commissioner of health.

(f) If a county which elects to implement county–based purchasing ceases to implement county–based purchasing, it is prohibited from assuming the responsibility of county–based purchasing for a period of five years from the date it discontinues purchasing.

[For text of subd 4, see M.S.1996]

Subd. 5. **Prospective per capita payment.** The commissioner shall establish the method and amount of payments for services. The commissioner shall annually contract with demonstration providers to provide services consistent with these established methods and amounts for payment.

If allowed by the commissioner, a demonstration provider may contract with an insurer, health care provider, nonprofit health service plan corporation, or the commissioner, to provide insurance or similar protection against the cost of care provided by the demonstration provider or to provide coverage against the risks incurred by demonstration providers under this section. The recipients enrolled with a demonstration provider are a permissible group under group insurance laws and chapter 62C, the Nonprofit Health Service Plan Corporations Act. Under this type of contract, the insurer or corporation may make benefit payments to a demonstration provider for services rendered or to be rendered to a recipient. Any insurer or nonprofit health service plan corporation licensed to do business in this state is authorized to provide this insurance or similar protection.

Payments to providers participating in the project are exempt from the requirements of sections 256.966 and 256B.03, subdivision 2. The commissioner shall complete development of capitation rates for payments before delivery of services under this section is begun.

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.

[For text of subd 5a, see M.S.1996]

Subd. 5b. **Prospective reimbursement rates.** For prepaid medical assistance and general assistance medical care program contract rates set by the commissioner under subdivision 5 and effective on or after January 1, 1998, capitation rates for nonmetropolitan counties shall on a weighted average be no less than 88 percent of the capitation rates for metropolitan counties, excluding Hennepin county. The commissioner shall make a pro rata adjustment in capitation rates paid to counties other than nonmetropolitan counties in order to make this provision budget neutral.

Subd. 5c. **Medical education and research trust fund.** (a) Beginning in January 1999 and each year thereafter:

(1) the commissioner of human services shall transfer an amount equal to the reduction in the prepaid medical assistance and prepaid general assistance medical care payments resulting from clause (2), excluding nursing facility and elderly waiver payments, to the medical education and research trust fund established under section 62J.69;

(2) the county medical assistance and general assistance medical care capitation base rate prior to plan specific adjustments shall be reduced 6.3 percent for Hennepin county, two percent for the remaining metropolitan counties, and 1.6 percent for nonmetropolitan Minnesota counties; and

(3) the amount calculated under clause (1) shall not be adjusted for subsequent changes to the capitation payments for periods already paid.

(b) This subdivision shall be effective upon approval of a federal waiver which allows federal financial participation in the medical education and research trust fund.

Subd. 5d. **Modification of payment dates effective January 1, 2001.** Effective for services rendered on or after January 1, 2001, capitation payments under this section and under section 256D.03 shall be made no earlier than the first day after the month of service.

[For text of subd 6, see M.S.1996]

Subd. 6a. **Nursing home services.** (a) Notwithstanding Minnesota Rules, part 9500.1457, subpart 1, item B, nursing facility services as defined in section 256B.0625, subdivision 2, which are provided in a nursing facility certified by the Minnesota department of health for services provided and eligible for payment under Medicaid, shall be covered under the prepaid medical assistance program for individuals who are not residing in a nursing facility at the time of enrollment in the prepaid medical assistance program. Liability for coverage of nursing facility services by a participating health plan is limited to 365 days for any person enrolled under the prepaid medical assistance program.

(b) For individuals enrolled in the Minnesota senior health options project authorized under subdivision 23, nursing facility services shall be covered according to the terms and conditions of the federal waiver governing that demonstration project.

Subd. 6b. **Elderly waiver services.** Notwithstanding Minnesota Rules, part 9500.1457, subpart 1, item C, elderly waiver services shall be covered under the prepaid medical assistance program for all individuals who are eligible according to section 256B.0915. For individuals enrolled in the Minnesota senior health options project authorized under subdivision 23, elderly waiver services shall be covered according to the terms and conditions of the federal waiver governing that demonstration project.

[For text of subds 7 to 22, see M.S.1996]

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 256L.12, subdivision 5, and Minnesota Rules, part 9505.5220, subpart 1, item A, if adopted, for the purpose of demonstrations under this subdivision, the commissioner may contract with managed care organizations 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.

Subd. 24. **Enrollment exemption.** Persons eligible for services under section 256B.0915 who have income in excess of the level permitted under section 256B.056 without a spenddown but below the MSA equivalent rate as defined in section 256I.03, subdivision 5, plus the medical assistance personal needs allowance as defined in section 256B.35, subdivision 1, paragraph (a), shall be exempt from mandatory enrollment in the prepaid medical assistance program under this section unless otherwise directed by the legislature, except for those persons who were initially enrolled in the prepaid medical assistance program while residing in a nursing home or whose income changed after initial enrollment in the prepaid medical assistance program. Nothing in this subdivision shall require persons who are required to enroll in the prepaid medical assistance program to disenroll from that program or from the Minnesota senior health options project after initial enrollment.

History: *1997 c 203 art 2 s 26; art 4 s 48–55*

NOTE: Subdivisions 6a and 6b, as added by Laws 1997, chapter 203, article 4, sections 53 and 54, are effective July 1, 1999. Laws 1997, chapter 203, article 4, section 74.

256B.692 COUNTY–BASED PURCHASING.

Subdivision 1. **In general.** County boards or groups of county boards may elect to purchase or provide health care services on behalf of persons eligible for medical assistance and general assistance medical care who would otherwise be required to or may elect to participate in the prepaid medical assistance or prepaid general assistance medical care programs according to sections 256B.69 and 256D.03. Counties that elect to purchase or provide health care under this section must provide all services included in prepaid managed care programs according to sections 256B.69, subdivisions 1 to 22, and 256D.03. County–based purchasing under this section is governed by section 256B.69, unless otherwise provided for under this section.

Subd. 2. **Duties of the commissioner of health.** Notwithstanding chapters 62D and 62N, a county that elects to purchase medical assistance and general assistance medical care in return for a fixed sum without regard to the frequency or extent of services furnished to any particular enrollee is not required to obtain a certificate of authority under chapter 62D or 62N. A county that elects to purchase medical assistance and general assistance medical care services under this section must satisfy the commissioner of health that the requirements of chapter 62D, applicable to health maintenance organizations, or chapter 62N, applicable to community integrated service networks, will be met. A county must also assure the commissioner of health that the requirements of section 72A.201 will be met. All enforcement and rulemaking powers available under chapters 62D and 62N are hereby granted to the commissioner of health with respect to counties that purchase medical assistance and general assistance medical care services under this section.

Subd. 3. **Requirements of the county board.** A county board that intends to purchase or provide health care under this section, which may include purchasing all or part of these services from health plans or individual providers on a fee–for–service basis, or providing these services directly, must demonstrate the ability to follow and agree to the following requirements:

(1) purchase all covered services for a fixed payment from the state that does not exceed the estimated state and federal cost that would have occurred under the prepaid medical assistance and general assistance medical care programs;

(2) ensure that covered services are accessible to all enrollees and that enrollees have a reasonable choice of providers, health plans, or networks when possible. If the county is also a provider of service, the county board shall develop a process to ensure that providers employed by the county are not the sole referral source and are not the sole provider of health care services if other providers, which meet the same quality and cost requirements are available;

(3) issue payments to participating vendors or networks in a timely manner;

(4) establish a process to ensure and improve the quality of care provided;

(5) provide appropriate quality and other required data in a format required by the state;

(6) provide a system for advocacy, enrollee protection, and complaints and appeals that is independent of care providers or other risk bearers and complies with section 256B.69;

(7) for counties within the seven–county metropolitan area, ensure that the implementation and operation of the Minnesota senior health options demonstration project, authorized under section 256B.69, subdivision 23, will not be impeded;

(8) ensure that all recipients that are enrolled in the prepaid medical assistance or general assistance medical care program will be transferred to county–based purchasing without utilizing the department's fee–for–service claims payment system;

(9) ensure that all recipients who are required to participate in county–based purchasing are given sufficient information prior to enrollment in order to make informed decisions; and

(10) ensure that the state and the medical assistance and general assistance medical care recipients will be held harmless for the payment of obligations incurred by the county if the county, or a health plan providing services on behalf of the county, or a provider participating in county–based purchasing becomes insolvent, and the state has made the payments due to the county under this section.

Subd. 4. **Payments to counties.** The commissioner shall pay counties that are purchasing or providing health care under this section a per capita payment for all enrolled recipients. Payments shall not exceed payments that otherwise would have been paid to health plans under medical assistance and general assistance medical care for that county or region. This payment is in addition to any administrative allocation to counties for education, enrollment, and advocacy. The state of Minnesota and the United States Department of Health and Human Services are not liable for any costs incurred by a county that exceed the payments to the county made under this subdivision. A county whose costs exceed the payments made by the state, or any affected enrollees or creditors of that county, shall have no rights under chapter 61B or section 62D.181. A county may assign risk for the cost of care to a third party.

Subd. 5. **County proposals.** (a) On or before September 1, 1997, a county board that wishes to purchase or provide health care under this section must submit a preliminary proposal that substantially demonstrates the county's ability to meet all the requirements of this section in response to criteria for proposals issued by the department on or before July 1, 1997. Counties submitting preliminary proposals must establish a local planning process that involves input from medical assistance and general assistance medical care recipients, recipient advocates, providers and representatives of local school districts, labor, and tribal government to advise on the development of a final proposal and its implementation.

(b) The county board must submit a final proposal on or before July 1, 1998, that demonstrates the ability to meet all the requirements of this section, including beginning enrollment on January 1, 1999.

(c) After January 1, 1999, for a county in which the prepaid medical assistance program is in existence, the county board must submit a preliminary proposal at least 15 months prior to termination of health plan contracts in that county and a final proposal six months prior to the health plan contract termination date in order to begin enrollment after the termination. Nothing in this section shall impede or delay implementation or continuation of the prepaid medical assistance and general assistance medical care programs in counties for which the board does not submit a proposal, or submits a proposal that is not in compliance with this section.

(d) The commissioner is not required to terminate contracts for the prepaid medical assistance and prepaid general assistance medical care programs that begin on or after September 1, 1997, in a county for which a county board has submitted a proposal under this paragraph, until two years have elapsed from the date of initial enrollment in the prepaid medical assistance and prepaid general assistance medical care programs.

Subd. 6. **Commissioner's authority.** The commissioner may:

(1) reject any preliminary or final proposal that substantially fails to meet the requirements of this section, or that the commissioner determines would substantially impair the state's ability to purchase health care services in other areas of the state, or would substantially impair an enrollee's choice of care systems when reasonable choice is possible, or would substantially impair the implementation and operation of the Minnesota senior health options demonstration project authorized under section 256B.69, subdivision 23; and

(2) assume operation of a county's purchasing of health care for enrollees in medical assistance and general assistance medical care in the event that the contract with the county is terminated.

Subd. 7. **Dispute resolution.** In the event the commissioner rejects a proposal under subdivision 6, the county board may request the recommendation of a three-person mediation panel. The commissioner shall resolve all disputes after taking into account the recommendations of the mediation panel. The panel shall be composed of one designee of the president of the association of Minnesota counties, one designee of the commissioner of human services, and one designee of the commissioner of health.

Subd. 8. **Appeals.** A county that conducts county-based purchasing shall be considered to be a prepaid health plan for purposes of section 256.045.

Subd. 9. **Federal approval.** The commissioner shall request any federal waivers and federal approval required to implement this section. County-based purchasing shall not be implemented without obtaining all federal approval required to maintain federal matching funds in the medical assistance program.

Subd. 10. **Report to the legislature.** The commissioner shall submit a report to the legislature by February 1, 1998, on the preliminary proposals submitted on or before September 1, 1997.

History: *1997 c 203 art 4 s 56*

256B.693 STATE-OPERATED SERVICES; MANAGED CARE.

Subdivision 1. **Proposals for managed care; role of state operated services.** Any proposal integrating state-operated services with managed care systems for persons with disabilities shall identify the specific role to be assumed by state-operated services and the funding

arrangement in which state–operated services shall effectively operate within the managed care initiative. The commissioner shall not approve or implement the initiative that consolidates funding appropriated for state–operated services with funding for managed care initiatives for persons with disabilities.

Subd. 2. **Study by the commissioner.** To help identify appropriate state–operated services for managed care systems, the commissioner of human services shall study the integration of state–operated services into public managed care systems and make recommendations to the legislature. The commissioner's study and recommendations shall include, but shall not be limited to, the following:

(1) identification of persons with disabilities on waiting lists for services, which could be provided by state–operated services;

(2) availability of crisis services to persons with disabilities;

(3) unmet service needs, which could be met by state–operated services; and

(4) deficiencies in managed care contracts and services, which hinder the placement and maintenance of persons with disabilities in community settings.

In conducting this study, the commissioner shall survey counties concerning their interest in and need for services that could be provided by state–operated services. The commissioner shall also consult with the appropriate exclusive bargaining unit representatives. The commissioner shall report findings to the legislature by February 1, 1998.

History: *1997 c 203 art 9 s 13*

256B.77 COORDINATED SERVICE DELIVERY SYSTEM FOR PEOPLE WITH DISABILITIES.

Subdivision 1. **Demonstration project for people with disabilities.** (a) The commissioner of human services, in cooperation with county authorities, shall develop and implement a demonstration project to create a coordinated service delivery system in which the full medical assistance benefit set for disabled persons eligible for medical assistance is provided and funded on a capitated basis. The demonstration period shall be a minimum of three years.

(b) Each demonstration site shall, under county authority, establish a local group to assist the commissioner in planning, designing, implementing, and evaluating the coordinated service delivery system in their area. This local group shall include county agencies, providers, consumers, family members, advocates, tribal governments, a local representative of labor, and advocacy organizations, and may include health plan companies. Consumers, families, and consumer representatives must be involved in the planning, implementation, and evaluation processes for the demonstration project.

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

(a) "Acute care" means hospital, physician, and other health and dental services covered in the medical assistance benefit set that are not specified in the intergovernmental contract or service delivery contract as continuing care services.

(b) "Additional services" means services developed and provided through the county administrative entity or service delivery organization, which are in addition to the medical assistance benefit set.

(c) "Advocate" means an individual who:

(1) has been authorized by the enrollee or the enrollee's legal representative to help the enrollee understand information presented and to speak on the enrollee's behalf, based on directions and decisions by the enrollee or the enrollee's legal representative; and

(2) represents only the enrollee and the enrollee's legal representative.

(d) "Advocacy organization" means an organization whose primary purpose is to advocate for the needs of persons with disabilities.

(e) "Alternative services" means services developed and provided through the county administrative entity or service delivery organization that are not part of the medical assistance benefit set.

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

(g) "Continuing care" means any services, including long–term support services, covered in the medical assistance benefit set that are not specified in the intergovernmental contract or service delivery contract as acute care.

(h) "County administrative entity" means the county administrative structure defined and designated by the county authority to implement the demonstration project under the direction of the county authority.

(i) "County authority" means the board of county commissioners or a single entity representing multiple boards of county commissioners.

(j) "Demonstration period" means the period of time during which county administrative entities or service delivery organizations will provide services to enrollees.

(k) "Demonstration site" means the geographic area in which eligible individuals may be included in the demonstration project.

(l) "Department" means the department of human services.

(m) "Emergency" means a condition that if not immediately treated could cause a person serious physical or mental disability, continuation of severe pain, or death. Labor and delivery is an emergency if it meets this definition.

(n) "Enrollee" means an eligible individual who is enrolled in the demonstration project.

(o) "Informed choice" means a voluntary decision made by the enrollee or the enrollee's legal representative, after becoming familiar with the alternatives, and having been provided sufficient relevant written and oral information at an appropriate comprehension level and in a manner consistent with the enrollee's or the enrollee's legal representative's primary mode of communication.

(p) "Informed consent" means the written agreement, or an agreement as documented in the record, by a competent enrollee, or an enrollee's legal representative, who:

(1) has the capacity to make reasoned decisions based on relevant information;

(2) is making decisions voluntarily and without coercion; and

(3) has knowledge to make informed choice.

(q) "Intergovernmental contract" means the agreement between the commissioner and the county authority.

(r) "Legal representative" means an individual who is legally authorized to provide informed consent or make informed choices on a person's behalf. A legal representative may be one of the following individuals:

(1) the parent of a minor who has not been emancipated;

(2) a court–appointed guardian or conservator of a person who is 18 years of age or older, in areas where legally authorized to make decisions;

(3) a guardian ad litem or special guardian or conservator, in areas where legally authorized to make decisions;

(4) legal counsel if so specified by the person; or

(5) any other legally authorized individual.

The county administrative entity is prohibited from acting as legal representative for any enrollee, as long as the provisions of subdivision 15 are funded.

(s) "Life domain areas" include, but are not limited to: home, family, education, employment, social environment, psychological and emotional health, self–care, independence, physical health, need for legal representation and legal needs, financial needs, safety, and cultural identification and spiritual needs.

(t) "Medical assistance benefit set" means the services covered under this chapter and accompanying rules which are provided according to the definition of medical necessity in Minnesota Rules, part 9505.0175, subpart 25.

(u) "Outcome" means the targeted behavior, action, or status of the enrollee that can be observed and or measured.

(v) "Personal support plan" means a document agreed to and signed by the enrollee and the enrollee's legal representative, if any, which describes:

(1) the assessed needs and strengths of the enrollee;

(2) the outcomes chosen by the enrollee or their legal representative;

(3) the amount, type, setting, start date, duration, and frequency of services and supports authorized by the county administrative entity or service delivery organization to achieve the chosen outcomes;

(4) a description of needed services and supports that are not the responsibility of the county administrative entity or service delivery organization and plans for addressing those needs;

(5) plans for referring to and coordinating between all agencies or individuals providing needed services and supports;

(6) the use of regulated treatment; and

(7) the transition of a child to the adult service system.

(w) "Regulated treatment" means any behaviorally altering medication of any classification or any aversive or deprivation procedure as defined in rules or statutes applicable to eligible individuals.

(x) "Service delivery contract" means the agreement between the commissioner or the county authority and the service delivery organization in those areas in which the county authority has provided written approval.

(y) "Service delivery organization" means an entity that is licensed as a health maintenance organization under chapter 62D or a community integrated service network under chapter 62N and is under contract with the commissioner or a county authority to participate in the demonstration project. If authorized in contract by the commissioner or the county authority, a service delivery organization participating in the demonstration project shall have the duties, responsibilities, and obligations defined under subdivisions 8, 9, 18, and 19.

(z) "Urgent situation" means circumstances in which care is needed as soon as possible, usually with 24 hours, to protect the health of an enrollee.

Subd. 3. **Assurances to the commissioner of health.** A county authority that elects to participate in a demonstration project for people with disabilities under this section is not required to obtain a certificate of authority under chapter 62D or 62N. A county authority that elects to participate in a demonstration project for people with disabilities under this section must assure the commissioner of health that the requirements of chapters 62D and 62N are met. All enforcement and rulemaking powers available under chapters 62D and 62N are granted to the commissioner of health with respect to the county authorities that contract with the commissioner to purchase services in a demonstration project for people with disabilities under this section.

Subd. 4. **Federal waivers.** The commissioner, in consultation with county authorities, shall request any authority from the United States Department of Health and Human Services that is necessary to implement the demonstration project under the medical assistance program; and authority to combine Medicaid and Medicare funding for service delivery to eligible individuals who are also eligible for Medicare, only if this authority does not preclude county authority participation under the waiver. Implementation of these programs may begin without authority to include Medicare funding. The commissioner may authorize county authorities to begin enrollment of eligible individuals upon federal approval but no earlier than July 1, 1998.

Subd. 5. **Demonstration sites.** The commissioner shall designate up to two demonstration sites with the approval of the county authority. Demonstration sites may include one county or a multicounty group. At least one of the sites shall implement a model specifically addressing the needs of eligible individuals with physical disabilities. By February 1, 1998, the commissioner and the county authorities shall submit to the chairs of the senate committee on health and family security and the house committee on health and human services a phased enrollment plan to ensure an orderly transition which protects the health and safety of enrollees and ensures continuity of services.

Subd. 6. **Responsibilities of the county authority.** (a) The commissioner may execute an intergovernmental contract with any county authority that demonstrates the ability to arrange for and coordinate services for enrollees covered under this section according to the

terms and conditions specified by the commissioner. With the written consent of the county authority, the commissioner may issue a request for proposals for service delivery organizations to provide portions of the medical assistance benefit set not contracted for by the county authority. County authorities that do not contract for the full medical assistance benefit set must ensure coordination with the entities responsible for the remainder of the covered services.

(b) No less than 90 days before the intergovernmental contract is executed, the county authority shall submit to the commissioner an initial proposal on how it will address the areas listed in this subdivision and subdivisions 1, 7, 8, 9, 12, 18, and 19. The county authority shall submit to the commissioner annual reports describing its progress in addressing these areas.

(c) Each county authority shall develop policies to address conflicts of interest, including public guardianship and representative payee issues.

(d) Each county authority shall annually evaluate the effectiveness of the service coordination provided according to subdivision 12 and shall take remedial or corrective action if the service coordination does not fulfill the requirements of that subdivision.

Subd. 7. **Eligibility and enrollment.** The commissioner, in consultation with the county authority, shall develop a process for enrolling eligible individuals in the demonstration project. A county or counties may limit enrollment in the demonstration project to one or more of the disability populations described in subdivision 7a, paragraph (b). Enrollment into county administrative entities and service delivery organizations shall be conducted according to the terms of the federal waiver. Enrollment of eligible individuals under the demonstration project may be phased in with approval of the commissioner. The commissioner shall ensure that eligibility for medical assistance and enrollment for the person are determined by individuals outside of the county administrative entity.

Subd. 7a. **Eligible individuals.** (a) Persons are eligible for the demonstration project as provided in this subdivision.

(b) "Eligible individuals" means those persons living in the demonstration site who are eligible for medical assistance and are disabled based on a disability determination under section 256B.055, subdivisions 7 and 12, or who are eligible for medical assistance and have been diagnosed as having:

(1) serious and persistent mental illness as defined in section 245.462, subdivision 20;

(2) severe emotional disturbance as defined in section 245.487, subdivision 6; or

(3) mental retardation or a related condition as defined in section 252.27, subdivision 1a.

Other individuals may be included at the option of the county authority based on agreement with the commissioner.

(c) Eligible individuals residing on a federally recognized Indian reservation may be excluded from participation in the demonstration project at the discretion of the tribal government based on agreement with the commissioner, in consultation with the county authority.

(d) Eligible individuals include individuals in excluded time status, as defined in chapter 256G. Enrollees in excluded time at the time of enrollment shall remain in excluded time status as long as they live in the demonstration site and shall be eligible for 90 days after placement outside the demonstration site if they move to excluded time status in a county within Minnesota other than their county of financial responsibility.

(e) A person who is a sexual psychopathic personality as defined in section 253B.02, subdivision 18a, or a sexually dangerous person as defined in section 253B.02, subdivision 18b, is excluded from enrollment in the demonstration project.

Subd. 8. **Responsibilities of the county administrative entity.** (a) The county administrative entity shall meet the requirements of this subdivision, unless the county authority or the commissioner, with written approval of the county authority, enters into a service delivery contract with a service delivery organization for any or all of the requirements contained in this subdivision.

(b) The county administrative entity shall enroll eligible individuals regardless of health or disability status.

(c) The county administrative entity shall provide all enrollees timely access to the medical assistance benefit set. Alternative services and additional services are available to enrollees at the option of the county administrative entity and may be provided if specified in the personal support plan. County authorities are not required to seek prior authorization from the department as required by the laws and rules governing medical assistance.

(d) The county administrative entity shall cover necessary services as a result of an emergency without prior authorization, even if the services were rendered outside of the provider network.

(e) The county administrative entity shall authorize necessary and appropriate services when needed and requested by the enrollee or the enrollee's legal representative in response to an urgent situation. Enrollees shall have 24–hour access to urgent care services coordinated by experienced disability providers who have information about enrollees' needs and conditions.

(f) The county administrative entity shall accept the capitation payment from the commissioner in return for the provision of services for enrollees.

(g) The county administrative entity shall maintain internal grievance and complaint procedures, including an expedited informal complaint process in which the county administrative entity must respond to verbal complaints within ten calendar days, and a formal grievance process, in which the county administrative entity must respond to written complaints within 30 calendar days.

(h) The county administrative entity shall provide a certificate of coverage, upon enrollment, to each enrollee and the enrollee's legal representative, if any, which describes the benefits covered by the county administrative entity, any limitations on those benefits, and information about providers and the service delivery network. This information must also be made available to prospective enrollees. This certificate must be approved by the commissioner.

(i) The county administrative entity shall present evidence of an expedited process to approve exceptions to benefits, provider network restrictions, and other plan limitations under appropriate circumstances.

(j) The county administrative entity shall provide enrollees or their legal representatives with written notice of their appeal rights under subdivision 16, and of ombudsman and advocacy programs under subdivisions 13 and 14, at the following times: upon enrollment, upon submission of a written complaint, when a service is reduced, denied, or terminated, or when renewal of authorization for ongoing service is refused.

(k) The county administrative entity shall determine immediate needs, including services, support, and assessments, within 30 calendar days of enrollment, or within a shorter time frame if specified in the intergovernmental contract.

(l) The county administrative entity shall assess the need for services of new enrollees within 60 calendar days of enrollment, or within a shorter time frame if specified in the intergovernmental contract, and periodically reassess the need for services for all enrollees.

(m) The county administrative entity shall ensure the development of a personal support plan for each person within 60 calendar days of enrollment, or within a shorter time frame if specified in the intergovernmental contract, unless otherwise agreed to by the enrollee and the enrollee's legal representative, if any. Until a personal support plan is developed and agreed to by the enrollee, enrollees must have access to the same amount, type, setting, duration, and frequency of covered services that they had at the time of enrollment unless other covered services are needed. For an enrollee who is not receiving covered services at the time of enrollment and for enrollees whose personal support plan is being revised, access to the medical assistance benefit set must be assured until a personal support plan is developed or revised. The personal support plan must be based on choices, preferences, and assessed needs and strengths of the enrollee. The service coordinator shall develop the personal support plan, in consultation with the enrollee or the enrollee's legal representative and other individuals requested by the enrollee. The personal support plan must be updated as needed or as requested by the enrollee. Enrollees may choose not to have a personal support plan.

(n) The county administrative entity shall ensure timely authorization, arrangement, and continuity of needed and covered supports and services.

(o) The county administrative entity shall offer service coordination that fulfills the responsibilities under subdivision 12 and is appropriate to the enrollee's needs, choices, and preferences, including a choice of service coordinator.

(p) The county administrative entity shall contract with schools and other agencies as appropriate to provide otherwise covered medically necessary medical assistance services as described in an enrollee's individual family support plan, as described in section 120.1701, or individual education plan, as described in chapter 120.

(q) The county administrative entity shall develop and implement strategies, based on consultation with affected groups, to respect diversity and ensure culturally competent service delivery in a manner that promotes the physical, social, psychological, and spiritual well–being of enrollees and preserves the dignity of individuals, families, and their communities.

(r) When an enrollee changes county authorities, county administrative entities shall ensure coordination with the entity that is assuming responsibility for administering the medical assistance benefit set to ensure continuity of supports and services for the enrollee.

(s) The county administrative entity shall comply with additional requirements as specified in the intergovernmental contract.

(t) To the extent that alternatives are approved under subdivision 17, county administrative entities must provide for the health and safety of enrollees and protect the rights to privacy and to provide informed consent.

Subd. 9. **Consumer choice and safeguards.** (a) The commissioner may require all eligible individuals to obtain services covered under this chapter through county authorities. Enrollees shall be given choices among a range of available providers with expertise in serving persons of their age and with their category of disability. If the county authority is also a provider of services covered under the demonstration project, other than service coordination, the enrollee shall be given the choice of at least one other provider of that service. The commissioner shall ensure that all enrollees have continued access to medically necessary covered services.

(b) The commissioner must ensure that a set of enrollee safeguards in the categories of access, choice, comprehensive benefits, access to specialist care, disclosure of financial incentives to providers, prohibition of exclusive provider contracting and gag clauses, legal representation, guardianship, representative payee, quality, rights and appeals, privacy, data collection, and confidentiality are in place prior to enrollment of eligible individuals.

(c) If multiple service delivery organizations are offered for acute or continuing care within a demonstration site, enrollees shall be given a choice of these organizations. A choice is required if the county authority operates its own health maintenance organization, community integrated service network, or similar plan. Enrollees shall be given opportunities to change enrollment in these organizations within 12 months following initial enrollment into the demonstration project and shall also be offered an annual open enrollment period, during which they are permitted to change their service delivery organization.

(d) Enrollees shall have the option to change their primary care provider once per month.

(e) The commissioner may waive the choice of provider requirements in paragraph (a) or the choice of service delivery organization requirements in paragraph (c) if the county authority can demonstrate that, despite reasonable efforts, no other provider of the service or service delivery organization can be made available within the cost and quality requirements of the demonstration project.

Subd. 10. **Capitation payment.** (a) The commissioner shall pay a capitation payment to the county authority and, when applicable under subdivision 6, paragraph (a), to the service delivery organization for each medical assistance eligible enrollee. The commissioner shall develop capitation payment rates for the initial contract period for each demonstration site in consultation with an independent actuary, to ensure that the cost of services under the demonstration project does not exceed the estimated cost for medical assistance services for the covered population under the fee–for–service system for the demonstration period. For each year of the demonstration project, the capitation payment rate shall be based on 96 percent of the projected per person costs that would otherwise have been paid under medical

assistance fee–for–service during each of those years. Rates shall be adjusted within the limits of the available risk adjustment technology, as mandated by section 62Q.03. In addition, the commissioner shall implement appropriate risk and savings sharing provisions with county administrative entities and, when applicable under subdivision 6, paragraph (a), service delivery organizations within the projected budget limits. Any savings beyond those allowed for the county authority, county administrative entity, or service delivery organization shall be first used to meet the unmet needs of eligible individuals. Payments to providers participating in the project are exempt from the requirements of sections 256.966 and 256B.03, subdivision 2.

(b) The commissioner shall monitor and evaluate annually the effect of the discount on consumers, the county authority, and providers of disability services. Findings shall be reported and recommendations made, as appropriate, to ensure that the discount effect does not adversely affect the ability of the county administrative entity or providers of services to provide appropriate services to eligible individuals, and does not result in cost shifting of eligible individuals to the county authority.

Subd. 11. **Integration of funding sources.** The county authority may integrate other local, state, and federal funding sources with medical assistance funding. The commissioner's approval is required for integration of state and federal funds but not for local funds. During the demonstration project period, county authorities must maintain the level of local funds expended during the previous calendar year for populations covered in the demonstration project. Excluding the state share of Medicaid payments, state appropriations for state–operated services shall not be integrated unless specifically approved by the legislature. The commissioner may approve integration of other state and federal funding if the intergovernmental contract includes assurances that the people who would have been served by these funds will receive comparable or better services. The commissioner may withdraw approval for integration of state and federal funds if the county authority does not comply with these assurances. If the county authority chooses to integrate funding, it must comply with the reporting requirements of the commissioner, as specified in the intergovernmental contract, to account for federal and state Medicaid expenditures and expenditures of local funds. The commissioner, upon the request and concurrence of a county authority, may transfer state grant funds that would otherwise be made available to the county authority to provide continuing care for enrollees to the medical assistance account and, within the limits of federal authority and available federal funding, the commissioner shall adjust the capitation based on the amount of this transfer.

Subd. 12. **Service coordination.** (a) For purposes of this section, "service coordinator" means an individual selected by the enrollee or the enrollee's legal representative and authorized by the county administrative entity or service delivery organization to work in partnership with the enrollee to develop, coordinate, and in some instances, provide supports and services identified in the personal support plan. Service coordinators may only provide services and supports if the enrollee is informed of potential conflicts of interest, is given alternatives, and gives informed consent. Eligible service coordinators are individuals age 18 or older who meet the qualifications as described in paragraph (b). Enrollees, their legal representatives, or their advocates are eligible to be service coordinators if they have the capabilities to perform the activities and functions outlined in paragraph (b). Providers licensed under chapter 245A to provide residential services, or providers who are providing residential services covered under the group residential housing program may not act as service coordinator for enrollees for whom they provide residential services. This does not apply to providers of short–term detoxification services. Each county administrative entity or service delivery organization may develop further criteria for eligible vendors of service coordination during the demonstration period and shall determine whom it contracts with or employs to provide service coordination. County administrative entities and service delivery organizations may pay enrollees or their advocates or legal representatives for service coordination activities.

(b) The service coordinator shall act as a facilitator, working in partnership with the enrollee to ensure that their needs are identified and addressed. The level of involvement of the

service coordinator shall depend on the needs and desires of the enrollee. The service coordinator shall have the knowledge, skills, and abilities to, and is responsible for:

(1) arranging for an initial assessment, and periodic reassessment as necessary, of supports and services based on the enrollee's strengths, needs, choices, and preferences in life domain areas;

(2) developing and updating the personal support plan based on relevant ongoing assessment;

(3) arranging for and coordinating the provisions of supports and services, including knowledgeable and skilled specialty services and prevention and early intervention services, within the limitations negotiated with the county administrative entity or service delivery organization;

(4) assisting the enrollee and the enrollee's legal representative, if any, to maximize informed choice of and control over services and supports and to exercise the enrollee's rights and advocate on behalf of the enrollee;

(5) monitoring the progress toward achieving the enrollee's outcomes in order to evaluate and adjust the timeliness and adequacy of the implementation of the personal support plan;

(6) facilitating meetings and effectively collaborating with a variety of agencies and persons, including attending individual family service plan and individual education plan meetings when requested by the enrollee or the enrollee's legal representative;

(7) soliciting and analyzing relevant information;

(8) communicating effectively with the enrollee and with other individuals participating in the enrollee's plan;

(9) educating and communicating effectively with the enrollee about good health care practices and risk to the enrollee's health with certain behaviors;

(10) having knowledge of basic enrollee protection requirements, including data privacy;

(11) informing, educating, and assisting the enrollee in identifying available service providers and accessing needed resources and services beyond the limitations of the medical assistance benefit set covered services; and

(12) providing other services as identified in the personal support plan.

(c) For the demonstration project, the qualifications and standards for service coordination in this section shall replace comparable existing provisions of existing statutes and rules governing case management for eligible individuals.

(d) The provisions of this subdivision apply only to the demonstration sites that begin implementation on July 1, 1998.

Subd. 13. **Ombudsman.** Enrollees shall have access to ombudsman services established in section 256B.031, subdivision 6, and advocacy services provided by the ombudsman for mental health and mental retardation established in sections 245.91 to 245.97. The managed care ombudsman and the ombudsman for mental health and mental retardation shall coordinate services provided to avoid duplication of services. For purposes of the demonstration project, the powers and responsibilities of the office of the ombudsman for mental health and mental retardation, as provided in sections 245.91 to 245.97 are expanded to include all eligible individuals, health plan companies, agencies, and providers participating in the demonstration project.

Subd. 14. **External advocacy.** In addition to ombudsman services, enrollees shall have access to advocacy services on a local or regional basis. The purpose of external advocacy includes providing individual advocacy services for enrollees who have complaints or grievances with the county administrative entity, service delivery organization, or a service provider; assisting enrollees to understand the service delivery system and select providers and, if applicable, a service delivery organization; and understand and exercise their rights as an enrollee. External advocacy contractors must demonstrate that they have the expertise to advocate on behalf of all categories of eligible individuals and are independent of the commissioner, county authority, county administrative entity, service delivery organization, or any service provider within the demonstration project.

These advocacy services shall be provided through the ombudsman for mental health and mental retardation directly, or under contract with private, nonprofit organizations, with funding provided through the demonstration project. The funding shall be provided annually to the ombudsman's office based on 0.1 percent of the projected per person costs that would otherwise have been paid under medical assistance fee–for–service during those years. Funding for external advocacy shall be provided for each year of the demonstration period. This funding is in addition to the capitation payment available under subdivision 10.

Subd. 15. **Public guardianship alternatives.** Each county authority with enrollees under public guardianship shall develop a plan to discharge all those public guardianships and establish appropriate private alternatives during the demonstration period.

The commissioner shall provide county authorities with funding for public guardianship alternatives during the first year of the demonstration project based on a proposal to establish private alternatives for a specific number of enrollees under public guardianship. Funding in subsequent years shall be based on the county authority's performance in achieving discharges of public guardianship and establishing appropriate alternatives. The commissioner may establish fiscal incentives to encourage county activity in this area. For each year of the demonstration period, an appropriation is available to the commissioner based on 0.2 percent of the projected per person costs that would otherwise have been paid under medical assistance fee–for–service for that year. This funding is in addition to the capitation payment available under subdivision 10.

Subd. 16. **Appeals.** Enrollees have the appeal rights specified in section 256.045. Enrollees may request the conciliation process as outlined under section 256.045, subdivision 4a. If an enrollee appeals in writing to the state agency on or before the latter of the effective day of the proposed action or the tenth day after they have received the decision of the county administrative entity or service delivery organization to reduce, suspend, terminate, or deny continued authorization for ongoing services which the enrollee had been receiving, the county administrative entity or service delivery organization must continue to authorize services at a level equal to the level it previously authorized until the state agency renders its decision.

Subd. 17. **Approval of alternatives.** The commissioner may approve alternatives to administrative rules if the commissioner determines that appropriate alternative measures are in place to protect the health, safety, and rights of enrollees and to assure that services are of sufficient quality to produce the outcomes described in the personal support plans. Prior approved waivers, if needed by the demonstration project, shall be extended. The commissioner shall not waive the rights or procedural protections under sections 245.825; 245.91 to 245.97; 252.41, subdivision 9; 256B.092, subdivision 10; 626.556; and 626.557; or procedures for the monitoring of psychotropic medications. Prohibited practices as defined in statutes and rules governing service delivery to eligible individuals are applicable to services delivered under this demonstration project.

Subd. 18. **Reporting.** Each county authority and service delivery organization, and their contracted providers, shall submit information as required by the commissioner in the intergovernmental contract or service delivery contract, including information about complaints, appeals, outcomes. costs, including spending on services, service utilization, identified unmet needs, services provided, rates of out–of–home placement of children, institutionalization, commitments, number of public guardianships discharged and alternatives to public guardianship established, the use of emergency services, and enrollee satisfaction. This information must be made available to enrollees and the public. A county authority under an intergovernmental contract and a service delivery organization under a service delivery contract to provide services must provide the most current listing of the providers who are participating in the plan. This listing must be provided to enrollees and be made available to the public. The commissioner, county authorities, and service delivery organizations shall also made all contracts and subcontracts related to the demonstration project available to the public.

Subd. 19. **Quality management and evaluation.** County authorities and service delivery organizations participating in this demonstration project shall provide information to the department as specified in the intergovernmental contract or service delivery contract for the

purpose of project evaluation. This information may include both process and outcome evaluation measures across areas that shall include enrollee satisfaction, service delivery, service coordination, individual outcomes, and costs. An independent evaluation of each demonstration site shall be conducted prior to expansion of the demonstration project to other sites.

Subd. 20. **Limitation on reimbursement.** The county administrative entity or service delivery organization may limit any reimbursement to providers not employed by or under contract with the county administrative entity or service delivery organization to the medical assistance rates paid by the commissioner of human services to providers for services to recipients not participating in the demonstration project.

Subd. 21. **County social services obligations.** For services that are outside of the medical assistance benefit set for enrollees in excluded time status, the county of financial responsibility must negotiate the provisions and payment of services with the county of service prior to the provision of services.

Subd. 22. **Minnesota Commitment Act services.** The county administrative entity or service delivery organization is financially responsible for all services for enrollees covered by the medical assistance benefit set and ordered by the court under the Minnesota Commitment Act, chapter 253B. The county authority shall seek input from the county administrative entity or service delivery organization in giving the court information about services the enrollee needs and least restrictive alternatives. The court order for services is deemed to comply with the definition of medical necessity in Minnesota Rules, part 9505.0175. The financial responsibility of the county administrative entity or service delivery organization for regional treatment center services to an enrollee while committed to the regional treatment center is limited to 45 days following commitment. Voluntary hospitalization for enrollees at regional treatment centers must be covered by the county administrative entity or service delivery organization if deemed medically necessary by the county administrative entity or service delivery organization. The regional treatment center shall not accept a voluntary admission of an enrollee without the authorization of the county administrative entity or service delivery organization. An enrollee will maintain enrollee status while receiving treatment under the Minnesota Commitment Act or voluntary services in a regional treatment center. For enrollees committed to the regional treatment center longer than 45 days, the commissioner may adjust the aggregate capitation payments, as specified in the intergovernmental contract or service delivery contract.

Subd. 23. **Stakeholder committee.** The commissioner shall appoint a stakeholder committee to review and provide recommendations on specifications for demonstration projects; intergovernmental contracts; service delivery contracts; alternatives to administrative rules proposed under subdivision 17; specific recommendations for legislation required for the implementation of this project, including changes to statutes; waivers of choice granted under subdivision 9, paragraph (e); and other demonstration project policies and procedures as requested by the commissioner. The stakeholder committee shall include representatives from the following stakeholders: consumers and their family members, advocates, advocacy organizations, service providers, state government, counties, and health plan companies. This stakeholder committee shall be in operation for the demonstration period. The county authorities shall continue to meet with state government to develop the intergovernmental partnership.

Subd. 24. **Report to the legislature.** (a) By February 15 of each year of the demonstration project, the commissioner shall report to the legislature on the progress of the demonstration project, including enrollee outcomes, enrollee satisfaction, fiscal information, other information as described in subdivision 18, recommendations from the stakeholder committee, and descriptions of any rules or other administrative procedures waived.

(b) The commissioner, in consultation with the counties and the stakeholder committee, shall study and define the county government function of service coordination and make recommendations to the legislature in the report due February 15, 1998.

Subd. 25. **Severability.** If any subdivision of this section is not approved by the United States Department of Health and Human Services, the commissioner, with the approval of the county authority, retains the authority to implement the remaining subdivisions.

Subd. 26. **Southern Minnesota health initiative pilot project.** When the commissioner contracts under subdivisions 1 and 6, paragraph (a), with the joint powers board for the southern Minnesota health initiative (SMHI) to participate in the demonstration project for persons with disabilities under subdivision 5, the commissioner shall also require health plans serving counties participating in the southern Minnesota health initiative under this section to contract with the southern Minnesota health initiative joint powers board to provide covered mental health and chemical dependency services for the nonelderly/nondisabled persons who reside in one of the counties and who are required or elect to participate in the prepaid medical assistance and general assistance medical care programs. Enrollees may obtain covered mental health and chemical dependency services through the SMHI or through other health plan contractors. Participation of the nonelderly/nondisabled with the SMHI is voluntary. The commissioner shall identify a monthly per capita payment amount that health plans are required to pay to the SMHI for all nonelderly/nondisabled recipients who choose the SMHI for their mental health and chemical dependency services.

History: *1997 c 203 art 8 s 1*