CHAPTER 256B

MEDICAL ASSISTANCE FOR NEEDY PERSONS

256B.04 DUTIES OF STATE AGENCY.

[For text of subds 1 to 13, see M.S.2006]

Subd. 14. **Competitive bidding.** (a) When determined to be effective, economical, and feasible, the commissioner may utilize volume purchase through competitive bidding and negotiation under the provisions of chapter 16C, to provide items under the medical assistance program including but not limited to the following:

(1) eyeglasses;

(2) oxygen. The commissioner shall provide for oxygen needed in an emergency situation on a short-term basis, until the vendor can obtain the necessary supply from the contract dealer;

(3) hearing aids and supplies; and

(4) durable medical equipment, including but not limited to:

(i) hospital beds;

(ii) commodes;

(iii) glide-about chairs;

(iv) patient lift apparatus;

(v) wheelchairs and accessories;

(vi) oxygen administration equipment;

(vii) respiratory therapy equipment;

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

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

(6) drugs.

(b) Rate changes under this chapter and chapters 256D and 256L do not affect contract payments under this subdivision unless specifically identified.

(c) The commissioner may not utilize volume purchase through competitive bidding and negotiation for special transportation services under the provisions of chapter 16C.

Subd. 14a. **Level of need determination.** Nonemergency medical transportation level of need determinations must be performed by a physician, a registered nurse working under direct supervision of a physician, a physician's assistant, a nurse practitioner, a licensed practical nurse, or a discharge planner. Nonemergency medical transportation level of need determinations must not be performed more than semiannually on any individual, unless the individual's circumstances have sufficiently changed so as to require a new level of need determination. Individuals residing in licensed nursing facilities are exempt from a level of need determination and are eligible for special transportation services until the individual no longer resides in a licensed nursing facility. If a person authorized by this subdivision to perform a level of need determination determines that an individual requires stretcher transportation, the individual is presumed to maintain that level of need until otherwise determined by a person authorized to perform a level of need determination, or for six months, whichever is sooner.

[For text of subds 15 to 19, see M.S.2006]

History: *2007 c 147 art 5 s 6,7*

256B.055 ELIGIBILITY CATEGORIES.

[For text of subds 1 to 13, see M.S.2006]

Subd. 14. **Persons detained by law.** (a) Medical assistance may be paid for an inmate of a correctional facility who is conditionally released as authorized under section 241.26, 244.065, or 631.425, if the individual does not require the security of a public detention facility and is housed in a halfway house or community correction center, or under house arrest and monitored by electronic surveillance in a residence approved by the commissioner of corrections, and if the individual meets the other eligibility requirements of this chapter.

(b) An individual who is enrolled in medical assistance, and who is charged with a crime and incarcerated for less than 12 months shall be suspended from eligibility at the time of incarceration until the individual is released. Upon release, medical assistance eligibility is reinstated without reapplication using a reinstatement process and form, if the individual is otherwise eligible.

(c) An individual, regardless of age, who is considered an inmate of a public institution as defined in Code of Federal Regulations, title 42, section 435.1009, is not eligible for medical assistance.

History: *2007 c 147 art 4 s 3*

256B.056 ELIGIBILITY REQUIREMENTS FOR MEDICAL ASSISTANCE.

[For text of subds 1 to 1c, see M.S.2006]

Subd. 1d. **Treatment of certain monetary gifts.** The commissioner shall disregard as income any portion of a monetary gift received by an applicant or enrollee that is designated to purchase a prosthetic device not covered by insurance, other third–party payers, or medical assistance.

[For text of subds 2 to 9, see M.S.2006]

Subd. 10. **Eligibility verification.** (a) The commissioner shall require women who are applying for the continuation of medical assistance coverage following the end of the 60–day postpartum period to update their income and asset information and to submit any required income or asset verification.

(b) The commissioner shall determine the eligibility of private–sector health care coverage for infants less than one year of age eligible under section 256B.055, subdivision 10, or 256B.057, subdivision 1, paragraph (d), and shall pay for private–sector coverage if this is determined to be cost–effective.

(c) The commissioner shall verify assets and income for all applicants, and for all recipients upon renewal.

[For text of subd 11, see M.S.2006]

History: *2007 c 147 art 4 s 4; art 5 s 8*

256B.057 ELIGIBILITY REQUIREMENTS FOR SPECIAL CATEGORIES.

[For text of subds 1 to 2, see M.S.2006]

Subd. 2c. **Extended coverage for children.** A child receiving medical assistance under subdivision 2, who becomes ineligible due to excess income, is eligible for two additional months of medical assistance. Eligibility under this section is effective following any coverage available under section 256B.0625.

A child eligible for extended coverage under this section is deemed automatically eligible for MinnesotaCare until renewal. MinnesotaCare coverage begins in accordance with section 256L.05, subdivision 3.

[For text of subds 3 to 10, see M.S.2006]

History: *2007 c 147 art 13 s 1*

NOTE: Subdivision 2c as added by Laws 2007, chapter 147, article 13, section 1, is effective October 1, 2008, or upon federal approval, whichever is later. Laws 2007, chapter 147, article 13, section 1, the effective date.

256B.06 ELIGIBILITY; MIGRANT WORKERS; CITIZENSHIP.

[For text of subd 3, see M.S.2006]

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. Citizens or nationals of the United States must cooperate in obtaining satisfactory documentary evidence of citizenship or nationality according to the requirements of the federal Deficit Reduction Act of 2005, Public Law 109–171.

(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);

(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 104–200;

(8) is a child of a noncitizen 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 104–200; or

(9) determined to be a Cuban or Haitian entrant as defined in section 501(e) of Public Law 96–422, the Refugee Education Assistance Act of 1980.

(c) All qualified noncitizens who were residing in the United States before August 22, 1996, who otherwise meet the eligibility requirements of this chapter, 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 this chapter, 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 this chapter 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 this chapter, are eligible for medical assistance under clauses (1) to (3). These individuals must cooperate with the United States Citizenship and Immigration Services 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 this chapter 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 this chapter, 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, nonimmigrants, or eligible for medical assistance as described in paragraph (j), and who are not covered by a group health plan or health insurance coverage according to Code of Federal Regulations, title 42, section 457.310, and who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance through the period of pregnancy, including labor and delivery, to the extent federal funds are available under title XXI of the Social Security Act, and the state children's health insurance program, followed by 60 days postpartum without federal financial participation.

(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) Beginning October 1, 2003, persons who are receiving care and rehabilitation services from a nonprofit center established to serve victims of torture and are otherwise ineligible for medical assistance under this chapter are eligible for medical assistance without federal financial participation. These individuals are eligible only for the period during which they are receiving services from the center. Individuals eligible under this paragraph shall not be required to participate in prepaid medical assistance.

[For text of subd 5, see M.S.2006]

History: *2007 c 13 art 1 s 25*

256B.0615 MENTAL HEALTH CERTIFIED PEER SPECIALIST.

Subdivision 1. **Scope.** Medical assistance covers mental health certified peers specialists services, as established in subdivision 2, subject to federal approval, if provided to recipients who are eligible for services under sections 256B.0622 and 256B.0623, and are provided by a certified peer specialist who has completed the training under subdivision 5.

Subd. 2. **Establishment.** The commissioner of human services shall establish a certified peer specialists program model, which:

(1) provides nonclinical peer support counseling by certified peer specialists;

(2) provides a part of a wraparound continuum of services in conjunction with other community mental health services;

(3) is individualized to the consumer; and

(4) promotes socialization, recovery, self–sufficiency, self–advocacy, development of natural supports, and maintenance of skills learned in other support services.

Subd. 3. **Eligibility.** Peer support services may be made available to consumers of the intensive rehabilitative mental health services under section 256B.0622 and adult rehabilitative mental health services under section 256B.0623.

Subd. 4. **Peer support specialist program providers.** The commissioner shall develop a process to certify peer support specialist programs, in accordance with the federal guidelines, in order for the program to bill for reimbursable services. Peer support programs may be freestanding or within existing mental health community provider centers.

Subd. 5. **Certified peer specialist training and certification.** The commissioner of human services shall develop a training and certification process for certified peer special-

ists, who must be at least 21 years of age and have a high school diploma or its equivalent. The candidates must have had a primary diagnosis of mental illness, be a current or former consumer of mental health services, and must demonstrate leadership and advocacy skills and a strong dedication to recovery. The training curriculum must teach participating consumers specific skills relevant to providing peer support to other consumers. In addition to initial training and certification, the commissioner shall develop ongoing continuing educational workshops on pertinent issues related to peer support counseling.

History: *2007 c 147 art 8 s 16*

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

[For text of subds 2 to 10, see M.S.2006]

Subd. 11. **Notice of relocation assistance.** The commissioner shall establish a process with the Centers for Independent Living that allows a person residing in a Minnesota nursing facility to receive needed information, consultation, and assistance from one of the centers about the available community support options that may enable the person to relocate to the community, if the person: (1) is under the age of 65, (2) has indicated a desire to live in the community, and (3) has signed a release of information authorized by the person or the person's appointed legal representative. The process established under this subdivision shall be coordinated with the long–term care consultation service activities established in section 256B.0911.

History: *2007 c 147 art 6 s 17*

256B.0622 INTENSIVE REHABILITATIVE MENTAL HEALTH SERVICES.

[For text of subd 1, see M.S.2006]

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

(a) "Intensive nonresidential rehabilitative mental health services" means adult rehabilitative mental health services as defined in section 256B.0623, subdivision 2, paragraph (a), except that these services are provided by a multidisciplinary staff using a total team approach consistent with assertive community treatment, the Fairweather Lodge treatment model, as defined by the standards established by the National Coalition for Community Living, and other evidence–based practices, and directed to recipients with a serious mental illness who require intensive services.

(b) "Intensive residential rehabilitative mental health services" means short–term, time–limited services provided in a residential setting to recipients who are in need of more restrictive settings and are at risk of significant functional deterioration if they do not receive these services. Services are designed to develop and enhance psychiatric stability, personal and emotional adjustment, self–sufficiency, and skills to live in a more independent setting. Services must be directed toward a targeted discharge date with specified client outcomes and must be consistent with the Fairweather Lodge treatment model as defined in paragraph (a), and other evidence–based practices.

(c) "Evidence–based practices" are nationally recognized mental health services that are proven by substantial research to be effective in helping individuals with serious mental illness obtain specific treatment goals.

(d) "Overnight staff" means a member of the intensive residential rehabilitative mental health treatment team who is responsible during hours when recipients are typically asleep.

(e) "Treatment team" means all staff who provide services under this section to recipients. At a minimum, this includes the clinical supervisor, mental health professionals as defined in section 245.462, subdivision 18, clauses (1) to (5); mental health practitioners as defined in section 245.462, subdivision 17; mental health rehabilitation workers under section 256B.0623, subdivision 5, clause (3); and certified peer specialists under section 256B.0615.

[For text of subds 3 to 10, see M.S.2006]

History: *2007 c 147 art 8 s 17*

256B.0623 ADULT REHABILITATIVE MENTAL HEALTH SERVICES COVERED.

[For text of subds 1 to 4, see M.S.2006]

Subd. 5. **Qualifications of provider staff.** Adult rehabilitative mental health services must be provided by qualified individual provider staff of a certified provider entity. Individual provider staff must be qualified under one of the following criteria:

(1) a mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (5). If the recipient has a current diagnostic assessment by a licensed mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (5), recommending receipt of adult mental health rehabilitative services, the definition of mental health professional for purposes of this section includes a person who is qualified under section 245.462, subdivision 18, clause (6), and who holds a current and valid national certification as a certified rehabilitation counselor or certified psychosocial rehabilitation practitioner;

(2) a mental health practitioner as defined in section 245.462, subdivision 17. The mental health practitioner must work under the clinical supervision of a mental health professional;

(3) a certified peer specialist under section 256B.0615. The certified peer specialist must work under the clinical supervision of a mental health professional; or

(4) a mental health rehabilitation worker. A mental health rehabilitation worker means a staff person working under the direction of a mental health practitioner or mental health professional and under the clinical supervision of a mental health professional in the implementation of rehabilitative mental health services as identified in the recipient's individual treatment plan who:

(i) is at least 21 years of age;

(ii) has a high school diploma or equivalent;

(iii) has successfully completed 30 hours of training during the past two years in all of the following areas: recipient rights, recipient–centered individual treatment planning, behavioral terminology, mental illness, co–occurring mental illness and substance abuse, psychotropic medications and side effects, functional assessment, local community resources, adult vulnerability, recipient confidentiality; and

(iv) meets the qualifications in subitem (A) or (B):

(A) has an associate of arts degree in one of the behavioral sciences or human services, or is a registered nurse without a bachelor's degree, or who within the previous ten years has:

(1) three years of personal life experience with serious and persistent mental illness;

(2) three years of life experience as a primary caregiver to an adult with a serious mental illness or traumatic brain injury; or

(3) 4,000 hours of supervised paid work experience in the delivery of mental health services to adults with a serious mental illness or traumatic brain injury; or

(B)(1) is fluent in the non–English language or competent in the culture of the ethnic group to which at least 20 percent of the mental health rehabilitation worker's clients belong;

(2) receives during the first 2,000 hours of work, monthly documented individual clinical supervision by a mental health professional;

(3) has 18 hours of documented field supervision by a mental health professional or practitioner during the first 160 hours of contact work with recipients, and at least six hours of field supervision quarterly during the following year;

(4) has review and cosignature of charting of recipient contacts during field supervision by a mental health professional or practitioner; and

(5) has 40 hours of additional continuing education on mental health topics during the first year of employment.

[For text of subds 6 to 14, see M.S.2006]

History: *2007 c 147 art 8 s 18*

256B.0625 COVERED SERVICES.

[For text of subds 1 to 3e, see M.S.2006]

Subd. 3f. **Circumcision.** Circumcision is not covered, unless the procedure is medically necessary.

[For text of subds 4 to 5, see M.S.2006]

Subd. 5a. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5b. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5c. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5d. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5e. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5f. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5g. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5h. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5i. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5j. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5k. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5l. **Intensive mental health outpatient treatment.** Medical assistance covers intensive mental health outpatient treatment for dialectical behavioral therapy for adults. The commissioner shall establish:

(1) certification procedures to ensure that providers of these services are qualified; and

(2) treatment protocols including required service components and criteria for admission, continued treatment, and discharge.

[For text of subds 6a to 13, see M.S.2006]

Subd. 13a. [Repealed, 2007 c 133 art 2 s 13]

Subd. 13c. **Formulary committee.** The commissioner, after receiving recommendations from professional medical associations and professional pharmacy associations, and consumer groups shall designate a Formulary Committee to carry out duties as described in subdivisions 13 to 13g. The Formulary Committee shall be comprised of four licensed physicians actively engaged in the practice of medicine in Minnesota one of whom must be actively engaged in the treatment of persons with mental illness; at least three licensed pharmacists actively engaged in the practice of pharmacy in Minnesota; and one consumer representative; the remainder to be made up of health care professionals who are licensed in their field and have recognized knowledge in the clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs. Members of the Formulary Committee shall not be employed by the Department of Human Services, but the committee shall be staffed by an employee of the department who shall serve as an ex officio, nonvoting member of the committee. The department's medical director shall also serve as an ex officio, nonvoting member for the committee. Committee members shall serve three–year terms and may be reappointed by the commissioner. The Formulary Committee shall meet at least quarterly. The commissioner may require more frequent Formulary Committee meetings as needed. An honorarium of $100 per meeting and reimbursement for mileage shall be paid to each committee member in attendance.

Subd. 13d. **Drug formulary.** (a) The commissioner shall establish a drug formulary. Its establishment and publication shall not be subject to the requirements of the Administrative Procedure Act, but the Formulary Committee shall review and comment on the formulary contents.

(b) The formulary shall not include:

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

(2) over–the–counter drugs, except as provided in subdivision 13;

(3) drugs used for weight loss, except that medically necessary lipase inhibitors may be covered for a recipient with type II diabetes;

(4) drugs when used for the treatment of impotence or erectile dysfunction;

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

(6) 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.

(c) If a single–source drug used by at least two percent of the fee–for–service medical assistance recipients is removed from the formulary due to the failure of the manufacturer to sign a rebate agreement with the Department of Health and Human Services, the commissioner shall notify prescribing practitioners within 30 days of receiving notification from the Centers for Medicare and Medicaid Services (CMS) that a rebate agreement was not signed.

[For text of subds 13e to 18, see M.S.2006]

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

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

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

(d) Regardless of the number of employees that an enrolled health care provider may have, medical assistance covers sign and oral language interpreter services when provided by an enrolled health care provider during the course of providing a direct, person–to–person covered health care service to an enrolled recipient with limited English proficiency or who has a hearing loss and uses interpreting services.

[For text of subds 19a to 19c, see M.S.2006]

Subd. 20. **Mental health case management.** (a) To the extent authorized by rule of the state agency, medical assistance covers case management services to persons with serious and persistent mental illness and children with severe emotional disturbance. Services provided under this section must meet the relevant standards in sections 245.461 to 245.4887, the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

(b) Entities meeting program standards set out in rules governing family community support services as defined in section 245.4871, subdivision 17, are eligible for medical assistance reimbursement for case management services for children with severe emotional disturbance when these services meet the program standards in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

(c) Medical assistance and MinnesotaCare payment for mental health case management shall be made on a monthly basis. In order to receive payment for an eligible child, the provider must document at least a face–to–face contact with the child, the child's parents, or the child's legal representative. To receive payment for an eligible adult, the provider must document:

(1) at least a face–to–face contact with the adult or the adult's legal representative; or

(2) at least a telephone contact with the adult or the adult's legal representative and document a face–to–face contact with the adult or the adult's legal representative within the preceding two months.

(d) Payment for mental health case management provided by county or state staff shall be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph (b), with separate rates calculated for child welfare and mental health, and within mental health, separate rates for children and adults.

(e) Payment for mental health case management provided by Indian health services or by agencies operated by Indian tribes may be made according to this section or other relevant federally approved rate setting methodology.

(f) Payment for mental health case management provided by vendors who contract with a county or Indian tribe shall be based on a monthly rate negotiated by the host county or tribe. The negotiated rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the county or tribe may negotiate a team rate with a vendor who is a member of the team. The team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county or tribe, except to reimburse the county or tribe for advance funding provided by the county or tribe to the vendor.

(g) If the service is provided by a team which includes contracted vendors, tribal staff, and county or state staff, the costs for county or state staff participation in the team shall be included in the rate for county–provided services. In this case, the contracted vendor, the tribal agency, and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, each entity must document, in the recipient's file, the need for team case management and a description of the roles of the team members.

(h) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for mental health case management shall be provided by the recipient's county of responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds used to match other federal funds. If the service is provided by a tribal agency, the nonfederal share, if any, shall be provided by the recipient's tribe. When this service is paid by the state without a federal share through fee–for–service, 50 percent of the cost shall be provided by the recipient's county of responsibility.

(i) Notwithstanding any administrative rule to the contrary, prepaid medical assistance, general assistance medical care, and MinnesotaCare include mental health case management. When the service is provided through prepaid capitation, the nonfederal share is paid by the state and the county pays no share.

(j) The commissioner may suspend, reduce, or terminate the reimbursement to a provider that does not meet the reporting or other requirements of this section. The county of responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the tribal agency, is responsible for any federal disallowances. The county or tribe may share this responsibility with its contracted vendors.

(k) The commissioner shall set aside a portion of the federal funds earned for county expenditures under this section to repay the special revenue maximization account under section 256.01, subdivision 2, clause (15). The repayment is limited to:

(1) the costs of developing and implementing this section; and

(2) programming the information systems.

(l) Payments to counties and tribal agencies for case management expenditures under this section shall only be made from federal earnings from services provided under this section. When this service is paid by the state without a federal share through fee–for–service, 50 percent of the cost shall be provided by the state. Payments to county–contracted vendors shall include the federal earnings, the state share, and the county share.

(m) Case management services under this subdivision do not include therapy, treatment, legal, or outreach services.

(n) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital, and the recipient's institutional care is paid by medical assistance, payment for case management services under this subdivision is limited to the last 180 days of the recipient's residency in that facility and may not exceed more than six months in a calendar year.

(o) Payment for case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

[For text of subds 20a and 22, see M.S.2006]

Subd. 23. **Day treatment services.** Medical assistance covers day treatment services as specified in sections 245.462, subdivision 8, and 245.4871, subdivision 10, that are provided under contract with the county board. Notwithstanding Minnesota Rules, part 9505.0323, subpart 15, the commissioner may set authorization thresholds for day treatment for adults according to section 256B.0625, subdivision 25. Notwithstanding Minnesota Rules, part 9505.0323, subpart 15, effective July 1, 2004, medical assistance covers day treatment services for children as specified under section 256B.0943.

[For text of subds 24 to 46, see M.S.2006]

Subd. 47. **Treatment foster care services.** Effective July 1, 2007, and subject to federal approval, medical assistance covers treatment foster care services according to section 256B.0946.

[For text of subd 48, see M.S.2006]

Subd. 49. **Community health worker.** (a) Medical assistance covers the care coordination and patient education services provided by a community health worker if the community health worker has:

(1) received a certificate from the Minnesota State Colleges and Universities System approved community health worker curriculum; or

(2) at least five years of supervised experience with an enrolled physician, registered nurse, or advanced practice registered nurse.

Community health workers eligible for payment under clause (2) must complete the certification program by January 1, 2010, to continue to be eligible for payment.

(b) Community health workers must work under the supervision of a medical assistance enrolled physician, registered nurse, or advanced practice registered nurse.

Subd. 50. **Self–directed supports option.** Upon federal approval, medical assistance covers the self–directed supports option as defined under section 256B.0657 and section 6087 of the Federal Deficit Reduction Act of 2005, Public Law 109–171.

Subd. 51. **Provider–directed care coordination services.** The commissioner shall develop and implement a provider–directed care coordination program for medical assistance recipients who are not enrolled in the prepaid medical assistance program and who are receiving services on a fee–for–service basis. This program provides payment to primary care clinics for care coordination for people who have complex and chronic medical conditions. Clinics must meet certain criteria such as the capacity to develop care plans; have a dedicated care coordinator; and have an adequate number of fee–for–service clients, evaluation mechanisms, and quality improvement processes to qualify for reimbursement. For purposes of this subdivision, a primary care clinic is a medical clinic designated as the patient's first point of contact for medical care, available 24 hours a day, seven days a week, that provides or arranges for the patient's comprehensive health care needs, and provides overall integration, coordination and continuity over time and referrals for specialty care.

Subd. 52. **Lead risk assessments.** (a) Effective October 1, 2007, or six months after federal approval, whichever is later, medical assistance covers lead risk assessments provided by a lead risk assessor who is licensed by the commissioner of health under section 144.9505 and employed by an assessing agency as defined in section 144.9501. Medical assistance covers a onetime on–site investigation of a recipient's home or primary residence to

determine the existence of lead so long as the recipient is under the age of 21 and has a venous blood lead level specified in section 144.9504, subdivision 2, paragraph (a).

(b) Medical assistance reimbursement covers the lead risk assessor's time to complete the following activities:

(1) gathering samples;

(2) interviewing family members;

(3) gathering data, including meter readings; and

(4) providing a report with the results of the investigation and options for reducing lead–based paint hazards.

Medical assistance coverage of lead risk assessment does not include testing of environmental substances such as water, paint, or soil or any other laboratory services. Medical assistance coverage of lead risk assessments is not included in the capitated services for children enrolled in health plans through the prepaid medical assistance program and the MinnesotaCare program.

(c) Payment for lead risk assessment must be cost–based and must meet the criteria for federal financial participation under the Medicaid program. The rate must be based on allowable expenditures from cost information gathered. Under section 144.9507, subdivision 5, federal medical assistance funds may not replace existing funding for lead–related activities. The nonfederal share of costs for services provided under this subdivision must be from state or local funds and is the responsibility of the agency providing the risk assessment. When the risk assessment is conducted by the commissioner of health, the state share must be from appropriations to the commissioner of health for this purpose. Eligible expenditures for the nonfederal share of costs may not be made from federal funds or funds used to match other federal funds. Any federal disallowances are the responsibility of the agency providing risk assessment services.

History: *2007 c 147 art 4 s 5–7; art 5 s 9; art 6 s 18; art 7 s 6,7; art 8 s 19–21; art 11 s 17; art 15 s 16; art 16 s 16*

NOTE: Subdivision 51 as added by Laws 2007, chapter 147, article 8, section 19, is effective July 1, 2008, and subject to federal approval. Laws 2007, chapter 147, article 8, section 19, the effective date.

NOTE: The amendment to subdivision 20 by Laws 2007, chapter 147, article 8, section 20, is effective January 1, 2009, except the amendments to paragraphs (h), (r), (s), and (t), are effective January 1, 2008. Laws 2007, chapter 147, article 8, section 20, the effective date.

NOTE: Subdivision 50 as added by Laws 2007, chapter 147, article 7, section 7, is effective upon federal approval of the state Medicaid plan amendment. Laws 2007, chapter 147, article 7, section 7, the effective date.

256B.0631 MEDICAL ASSISTANCE CO–PAYMENTS.

Subdivision 1. **Co–payments.** (a) Except as provided in subdivision 2, the medical assistance benefit plan shall include the following co–payments for all recipients, effective for services provided on or after October 1, 2003, and before January 1, 2009:

(1) $3 per nonpreventive visit. For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

(2) $3 for eyeglasses;

(3) $6 for nonemergency visits to a hospital–based emergency room; and

(4) $3 per brand–name drug prescription and $1 per generic drug prescription, subject to a $12 per month maximum for prescription drug co–payments. No co–payments shall apply to antipsychotic drugs when used for the treatment of mental illness.

(b) Except as provided in subdivision 2, the medical assistance benefit plan shall include the following co–payments for all recipients, effective for services provided on or after January 1, 2009:

(1) $6 for nonemergency visits to a hospital–based emergency room; and

(2) $3 per brand–name drug prescription and $1 per generic drug prescription, subject to a $7 per month maximum for prescription drug co–payments. No co–payments shall apply to antipsychotic drugs when used for the treatment of mental illness.

(c) Recipients of medical assistance are responsible for all co–payments in this subdivision.

[For text of subd 2, see M.S.2006]

Subd. 3. **Collection.** (a) The medical assistance reimbursement to the provider shall be reduced by the amount of the co–payment, except that reimbursement for prescription drugs shall not be reduced once a recipient has reached the $12 per month maximum or the $7 per month maximum effective January 1, 2009, for prescription drug co–payments.

(b) The provider collects the co–payment from the recipient. Providers may not deny services to recipients who are unable to pay the co–payment.

(c) Medical assistance reimbursement to fee–for–service providers and payments to managed care plans shall not be increased as a result of the removal of the co–payments effective January 1, 2009.

[For text of subd 4, see M.S.2006]

History: *2007 c 147 art 5 s 10,11*

NOTE: Subdivision 4 is repealed by Laws 2007, chapter 147, article 5, section 41, effective January 1, 2009. Laws 2007, chapter 147, article 5, section 41, paragraph (d).

256B.0636 CONTROLLED SUBSTANCE PRESCRIPTIONS; ABUSE PREVENTION.

The commissioner of human services shall develop and implement a plan to:

(1) review utilization patterns of Minnesota health care program enrollees for controlled substances listed in section 152.02, subdivisions 3 and 4, and those substances defined by the Board of Pharmacy under section 152.02, subdivisions 8 and 12;

(2) develop a mechanism to address abuses both for fee–for–service Minnesota health care program enrollees and those enrolled in managed care plans; and

(3) provide education to Minnesota health care program enrollees on the proper use of controlled substances.

For purposes of this section, "Minnesota health care program" means medical assistance, MinnesotaCare, or general assistance medical care.

History: *2007 c 147 art 12 s 11*

256B.0644 REIMBURSEMENT UNDER OTHER STATE HEALTH CARE PROGRAMS.

(a) A vendor of medical care, as defined in section 256B.02, subdivision 7, and a health maintenance organization, as defined in chapter 62D, must participate as a provider or contractor in the medical assistance program, 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.19. The limitations on insurance plans offered to local government employees shall not be applicable in geographic areas where provider participation is limited by managed care contracts with the Department of Human Services.

(b) 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 service 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 service 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, or the provider accepts new medical assistance and MinnesotaCare patients who are children with special health care needs. For purposes of this section, "children with special health care needs" means children up to age 18 who: (i) require health and related services beyond that required by children generally; and (ii) have or are at risk for a chronic physical, developmental, behavioral, or emotional condition, including: bleeding and coagulation disorders; immunodeficiency disorders; cancer; endocrinopathy; developmental disabilities; epilepsy, cerebral palsy, and other neurological diseases; visual impairment or deafness; Down syndrome and other genetic disorders; autism; fetal alcohol syndrome; and other conditions designated by the commissioner after consultation with representatives of pediatric dental providers and consumers.

(c) Patients seen on a volunteer basis by the provider at a location other than the provider's usual place of practice may be considered in meeting the participation requirement in this section. The commissioner shall establish participation requirements for health maintenance organizations. The commissioner shall provide lists of participating medical assistance providers on a quarterly basis to the commissioner of 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: *2007 c 147 art 5 s 12*

256B.0651 HOME CARE SERVICES.

[For text of subds 1 to 6, see M.S.2006]

Subd. 7. **Prior authorization; time limits.** The commissioner or the commissioner's designee shall determine the time period for which a prior authorization shall be effective and, if flexible use has been requested, whether to allow the flexible use option. 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. A personal care provider agency must request a new personal care assistant services assessment, or service update if allowed, at least 60 days prior to the end of the current prior authorization time period. The request for the assessment must be made on a form approved by the commissioner. Under no circumstances, other than the exceptions in subdivision 4, 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 subdivision 8, 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.

[For text of subds 8 to 13, see M.S.2006]

History: *2007 c 147 art 7 s 8*

256B.0653 HOME HEALTH AGENCY COVERED SERVICES.

(a) **Homecare; skilled nurse visits.** "Skilled nurse visits" are provided in a recipient's residence under a plan of care or service plan that specifies a level of care which the nurse is qualified to provide. These services are:

(1) nursing services according to the written plan of care or service plan and accepted standards of medical and nursing practice in accordance with chapter 148;

(2) services which due to the recipient's medical condition may only be safely and effectively provided by a registered nurse or a licensed practical nurse;

(3) assessments performed only by a registered nurse; and

(4) teaching and training the recipient, the recipient's family, or other caregivers requiring the skills of a registered nurse or licensed practical nurse.

(b) **Telehomecare; skilled nurse visits.** Medical assistance covers skilled nurse visits according to section 256B.0625, subdivision 6a, provided via telehomecare, for services which do not require hands–on care between the home care nurse and recipient. The provision of telehomecare must be made via live, two–way interactive audiovisual technology and may be augmented by utilizing store–and–forward technologies. Store–and–forward technology includes telehomecare services that do not occur in real time via synchronous transmissions, and that do not require a face–to–face encounter with the recipient for all or any part of any such telehomecare visit. Individually identifiable patient data obtained through real–time or store–and–forward technology must be maintained as health records according to sections 144.291 to 144.298. If the video is used for research, training, or other purposes unrelated to the care of the patient, the identity of the patient must be concealed. A communication between the home care nurse and recipient that consists solely of a telephone conversation, facsimile, electronic mail, or a consultation between two health care practitioners, is not to be considered a telehomecare visit. Multiple daily skilled nurse visits provided via telehomecare are allowed. Coverage of telehomecare is limited to two visits per day. All skilled nurse visits provided via telehomecare must be prior authorized by the commissioner or the commissioner's designee and will be covered at the same allowable rate as skilled nurse visits provided in–person.

(c) **Therapies through home health agencies.** (1) **Physical therapy.** Medical assistance covers physical therapy and related services, including specialized maintenance therapy. Services provided by a physical therapy assistant shall be reimbursed at the same rate as services performed by a physical therapist when the services of the physical therapy assistant are provided under the direction of a physical therapist who is on the premises. Services provided by a physical therapy assistant that are provided under the direction of a physical therapist who is not on the premises shall be reimbursed at 65 percent of the physical therapist rate. Direction of the physical therapy assistant must be provided by the physical therapist as described in Minnesota Rules, part 9505.0390, subpart 1, item B. The physical therapist and physical therapist assistant may not both bill for services provided to a recipient on the same day.

(2) **Occupational therapy.** Medical assistance covers occupational therapy and related services, including specialized maintenance therapy. Services provided by an occupational therapy assistant shall be reimbursed at the same rate as services performed by an occupational therapist when the services of the occupational therapy assistant are provided under the direction of the occupational therapist who is on the premises. Services provided by an occupational therapy assistant under the direction of an occupational therapist who is not on the premises shall be reimbursed at 65 percent of the occupational therapist rate. Direction of the occupational therapy assistant must be provided by the occupational therapist as described in Minnesota Rules, part 9505.0390, subpart 1, item B. The occupational therapist and occupational therapist assistant may not both bill for services provided to a recipient on the same day.

History: *2007 c 147 art 10 s 15*

256B.0655 PERSONAL CARE ASSISTANT SERVICES.

[For text of subds 1 and 1a, see M.S.2006]

Subd. 1b. **Assessment.** "Assessment" means a review and evaluation of a recipient's need for home care services conducted in person. Assessments for personal care assistant

services shall be conducted by the county public health nurse or a certified public health nurse under contract with the county. A face–to–face assessment must include: documentation of health status, determination of need, evaluation of service effectiveness, identification of appropriate services, service plan development or modification, coordination of services, referrals and follow–up to appropriate payers and community resources, completion of required reports, recommendation of service authorization, and consumer education. Once the need for personal care assistant services is determined under this section or sections 256B.0651, 256B.0653, 256B.0654, and 256B.0656, the county public health nurse or certified public health nurse under contract with the county is responsible for communicating this recommendation to the commissioner and the recipient. A face–to–face assessment for personal care assistant services is conducted on those recipients who have never had a county public health nurse assessment. A face–to–face assessment must occur at least annually or when there is a significant change in the recipient's condition or when there is a change in the need for personal care assistant services. A service update may substitute for the annual face–to–face assessment when there is not a significant change in recipient condition or a change in the need for personal care assistant service. A service update may be completed by telephone, used when there is no need for an increase in personal care assistant services, and used for two consecutive assessments if followed by a face–to–face assessment. A service update must be completed on a form approved by the commissioner. A service update or review for temporary increase includes a review of initial baseline data, evaluation of service effectiveness, redetermination of service need, modification of service plan and appropriate referrals, update of initial forms, obtaining service authorization, and on going consumer education. Assessments must be completed on forms provided by the commissioner within 30 days of a request for home care services by a recipient or responsible party or personal care provider agency.

[For text of subds 1c to 1e, see M.S.2006]

Subd. 1f. **Personal care assistant.** (a) "Personal care assistant" means a person who:

(1) is at least 18 years old, except for persons 16 to 18 years of age who participated in a related school–based job training program or have completed a certified home health aide competency evaluation;

(2) is able to effectively communicate with the recipient and personal care provider organization;

(3) effective July 1, 1996, has completed one of the training requirements as specified in paragraph (b);

(4) has the ability to, and provides covered personal care assistant services according to the recipient's care plan, responds appropriately to recipient needs, and reports changes in the recipient's condition to the supervising qualified professional or physician;

(5) is not a consumer of personal care assistant services;

(6) maintains daily written records detailing:

(i) the actual services provided to the recipient; and

(ii) the amount of time spent providing the services; and

(7) is subject to criminal background checks and procedures specified in chapter 245C.

(b) Personal care assistant training must include successful completion of one or more training requirements in:

(1) a nursing assistant training program or its equivalent for which competency as a nursing assistant is determined according to a test administered by the Minnesota State Board of Technical Colleges;

(2) a homemaker home health aide preservice training program using a curriculum recommended by the Department of Health;

(3) an accredited educational program for registered nurses or licensed practical nurses;

(4) a training program that provides the assistant with skills required to perform personal care assistant services specified in subdivision 2; or

(5) a determination by the personal care provider that the assistant has, through training or experience, the skills required to perform the personal care services specified in subdivision 2.

[For text of subds 1g to 2, see M.S.2006]

Subd. 3. **Assessment and service plan.** Assessments under subdivision 1b and sections 256B.0651, subdivision 1, paragraph (b), and 256B.0654, 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. A personal care provider agency must use a form approved by the commissioner to request a county public health nurse to conduct a personal care assistant services assessment. When requesting a reassessment, the personal care provider agency must notify the county and the recipient at least 60 days prior to the end of the current prior authorization for personal care assistant services. The recipient notice shall include information on the recipient's appeal rights. Within 30 days of recipient or responsible party or personal care assistant provider agency 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. Notwithstanding the provisions of subdivision 8, the commissioner shall maximize federal financial participation to pay for public health nurse assessments for personal care services. For personal care assistant 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 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. The request must be made on a form approved by the commissioner. 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. If the change in service need is due to a change in medical condition, a new physician's statement of need required by section 256B.0625, subdivision 19c, must be obtained.

(3) To continue to receive personal care assistant services after the first year, the recipient or the responsible party, in conjunction with the public health nurse, may complete a service update on forms developed by the commissioner according to criteria and procedures in subdivisions 1a to 1i and sections 256B.0651, subdivision 1; 256B.0653; and 256B.0654, subdivision 1.

[For text of subds 4 to 7, see M.S.2006]

Subd. 8. **Public health nurse assessment rate.** (a) The reimbursement rates for public health nurse visits that relate to the provision of personal care services under this section and section 256B.0625, subdivision 19a, are:

(i) $210.50 for a face–to–face assessment visit;

(ii) $105.25 for each service update; and

(iii) $105.25 for each request for a temporary service increase.

(b) The rates specified in paragraph (a) must be adjusted to reflect provider rate increases for personal care assistant services that are approved by the legislature for the fiscal year ending June 30, 2000, and subsequent fiscal years. Any requirements applied by the legislature to provider rate increases for personal care assistant services also apply to adjustments under this paragraph.

(c) Effective July 1, 2008, the payment rate for an assessment under this section and section 256B.0651 shall be reduced by 25 percent when the assessment is not completed on time or the service agreement documentation is not submitted in time to continue services. The commissioner shall recoup these amounts on a retroactive basis.

[For text of subds 9 and 10, see M.S.2006]

Subd. 11. **Personal care provider responsibilities.** The personal care provider shall:

(1) employ or contract with services staff to provide personal care services and to train services staff as necessary;

(2) supervise the personal care services as provided in subdivision 2, paragraph (f);

(3) employ a personal care assistant that a qualified recipient brings to the personal care provider as the recipient's choice of assistant and who meets the employment qualifications of the provider, except that a personal care provider who must comply with the requirements of a governmental personnel administration system is exempt from this clause;

(4) bill the medical assistance program for a personal care service by the personal care assistant and a visit by the qualified professional supervising the personal care assistant;

(5) establish a grievance mechanism to resolve consumer complaints about personal care services, including the personal care provider's decision whether to employ the qualified recipient's choice of a personal care assistant;

(6) keep records as required in Minnesota Rules, parts 9505.2160 to 9505.2195;

(7) perform functions and provide services specified in the personal care provider's contract;

(8) comply with applicable rules and statutes; and

(9) perform other functions as necessary to carry out the responsibilities in clauses (1) to (8).

Subd. 12. **Personal care provider; employment prohibition.** A personal care provider shall not employ a person to provide personal care service for a qualified recipient if the person:

(1) refuses to provide full disclosure of criminal history records as specified in subdivision 1g, clause (1);

(2) has been convicted of a crime that directly relates to the occupation of providing personal care services to a qualified recipient;

(3) has jeopardized the health or welfare of a vulnerable adult through physical abuse, sexual abuse, or neglect as defined in section 626.557; or

(4) is misusing or is dependent on mood–altering chemicals, including alcohol, to the extent that the personal care provider knows or has reason to believe that the use of chemicals has a negative effect on the person's ability to provide personal care services or the use of chemicals is apparent during the hours the person is providing personal care services.

Subd. 13. **Supervision of personal care services.** A personal care service to a qualified recipient as described in subdivision 4 shall be under the supervision of a qualified professional who shall have the following duties:

(1) ensure that the personal care assistant is capable of providing the required personal care services through direct observation of the assistant's work or through consultation with the qualified recipient;

(2) ensure that the personal care assistant is knowledgeable about the plan of personal care services before the personal care assistant performs personal care services;

(3) ensure that the personal care assistant is knowledgeable about essential observations of the recipient's health, and about any conditions that should be immediately brought to the attention of either the qualified professional or the attending physician;

(4) evaluate the personal care services of a recipient through direct observation of the personal care assistant's work or through consultation with the qualified recipient. Evaluation shall be made:

(i) within 14 days after the placement of a personal care assistant with the qualified recipient;

(ii) at least once every 30 days during the first 90 days after the qualified recipient first receives personal care services according to the plan of personal care service; and

(iii) at least once every 120 days following the period of evaluations in item (ii). The qualified professional shall record in writing the results of the evaluation and actions taken to correct any deficiencies in the work of the personal care assistant;

(5) review, together with the recipient, and revise, as necessary, the plan of personal care services at least once every 120 days after a plan of personal care services is developed;

(6) ensure that the personal care assistant and recipient are knowledgeable about a change in the plan of personal care services;

(7) ensure that records are kept, showing the services provided to the recipient by the personal care assistant as described in subdivision 2, paragraph (f), and the time spent providing the services;

(8) determine that a qualified recipient is still capable of directing the recipient's own care or has a responsible party; and

(9) determine with a physician that a recipient is a qualified recipient.

History: *2007 c 147 art 6 s 19–22; art 7 s 9–11*

256B.0657 SELF–DIRECTED SUPPORTS OPTION.

Subdivision 1. **Definition.** "Self–directed supports option" means personal assistance, supports, items, and related services purchased under an approved budget plan and budget by a recipient.

Subd. 2. **Eligibility.** (a) The self–directed supports option is available to a person who:

(1) is a recipient of medical assistance as determined under sections 256B.055, 256B.056, and 256B.057, subdivision 9;

(2) is eligible for personal care assistant services under section 256B.0655;

(3) lives in the person's own apartment or home, which is not owned, operated, or controlled by a provider of services not related by blood or marriage;

(4) has the ability to hire, fire, supervise, establish staff compensation for, and manage the individuals providing services, and to choose and obtain items, related services, and supports as described in the participant's plan. If the recipient is not able to carry out these functions but has a legal guardian or parent to carry them out, the guardian or parent may fulfill these functions on behalf of the recipient; and

(5) has not been excluded or disenrolled by the commissioner.

(b) The commissioner may disenroll or exclude recipients, including guardians and parents, under the following circumstances:

(1) recipients who have been restricted by the Primary Care Utilization Review Committee may be excluded for a specified time period;

(2) recipients who exit the self–directed supports option during the recipient's service plan year shall not access the self–directed supports option for the remainder of that service plan year; and

(3) when the department determines that the recipient cannot manage recipient responsibilities under the program.

Subd. 3. **Eligibility for other services.** Selection of the self–directed supports option by a recipient shall not restrict access to other medically necessary care and services furnished under the state plan medical assistance benefit, including home care targeted case management, except that a person receiving home and community–based waiver services, a family support grant, or a consumer support grant is not eligible for funding under the self–directed supports option.

Subd. 4. **Assessment requirements.** (a) The self–directed supports option assessment must meet the following requirements:

(1) it shall be conducted by the county public health nurse or a certified public health nurse under contract with the county;

(2) it shall be conducted face–to–face in the recipient's home initially, and at least annually thereafter; when there is a significant change in the recipient's condition; and when there

is a change in the need for personal care assistant services. A recipient who is residing in a facility may be assessed for the self–directed support option for the purpose of returning to the community using this option; and

(3) it shall be completed using the format established by the commissioner.

(b) The results of the assessment and recommendations shall be communicated to the commissioner and the recipient by the county public health nurse or certified public health nurse under contract with the county.

Subd. 5. **Self–directed supports option plan requirements.** (a) The plan for the self–directed supports option must meet the following requirements:

(1) the plan must be completed using a person–centered process that:

(i) builds upon the recipient's capacity to engage in activities that promote community life;

(ii) respects the recipient's preferences, choices, and abilities;

(iii) involves families, friends, and professionals in the planning or delivery of services or supports as desired or required by the recipient; and

(iv) addresses the need for personal care assistant services identified in the recipient's self–directed supports option assessment;

(2) the plan shall be developed by the recipient or by the guardian of an adult recipient or by a parent or guardian of a minor child, with the assistance of an enrolled medical assistance home care targeted case manager provider who meets the requirements established for using a person–centered planning process and shall be reviewed at least annually upon reassessment or when there is a significant change in the recipient's condition; and

(3) the plan must include the total budget amount available divided into monthly amounts that cover the number of months of personal care assistant services authorization included in the budget. The amount used each month may vary, but additional funds shall not be provided above the annual personal care assistant services authorized amount unless a change in condition is documented.

(b) The commissioner shall:

(1) establish the format and criteria for the plan as well as the requirements for providers who assist with plan development;

(2) review the assessment and plan and, within 30 days after receiving the assessment and plan, make a decision on approval of the plan;

(3) notify the recipient, parent, or guardian of approval or denial of the plan and provide notice of the right to appeal under section 256.045; and

(4) provide a copy of the plan to the fiscal support entity selected by the recipient.

Subd. 6. **Services covered.** (a) Services covered under the self–directed supports option include:

(1) personal care assistant services under section 256B.0655; and

(2) items, related services, and supports, including assistive technology, that increase independence or substitute for human assistance to the extent expenditures would otherwise be used for human assistance.

(b) Items, supports, and related services purchased under this option shall not be considered home care services for the purposes of section 144A.43.

Subd. 7. **Noncovered services.** Services or supports that are not eligible for payment under the self–directed supports option include:

(1) services, goods, or supports that do not benefit the recipient;

(2) any fees incurred by the recipient, such as Minnesota health care program fees and co–pays, legal fees, or costs related to advocate agencies;

(3) insurance, except for insurance costs related to employee coverage or fiscal support entity payments;

(4) room and board and personal items that are not related to the disability, except that medically prescribed specialized diet items may be covered if they reduce the need for human assistance;

(5) home modifications that add square footage;

(6) home modifications for a residence other than the primary residence of the recipient, or in the event of a minor with parents not living together, the primary residences of the parents;

(7) expenses for travel, lodging, or meals related to training the recipient, the parent or guardian of an adult recipient, or the parent or guardian of a minor child, or paid or unpaid caregivers that exceed $500 in a 12–month period;

(8) experimental treatment;

(9) any service or item covered by other medical assistance state plan services, including prescription and over–the–counter medications, compounds, and solutions and related fees, including premiums and co–payments;

(10) membership dues or costs, except when the service is necessary and appropriate to treat a physical condition or to improve or maintain the recipient's physical condition. The condition must be identified in the recipient's plan of care and monitored by a Minnesota health care program enrolled physician;

(11) vacation expenses other than the cost of direct services;

(12) vehicle maintenance or modifications not related to the disability;

(13) tickets and related costs to attend sporting or other recreational events; and

(14) costs related to Internet access, except when necessary for operation of assistive technology, to increase independence, or to substitute for human assistance.

Subd. 8. **Self–directed budget requirements.** The budget for the provision of the self–directed service option shall be equal to the greater of either:

(1) the annual amount of personal care assistant services under section 256B.0655 that the recipient has used in the most recent 12–month period; or

(2) the amount determined using the consumer support grant methodology under section 256.476, subdivision 11, except that the budget amount shall include the federal and nonfederal share of the average service costs.

Subd. 9. **Quality assurance and risk management.** (a) The commissioner shall establish quality assurance and risk management measures for use in developing and implementing self–directed plans and budgets that (1) recognize the roles and responsibilities involved in obtaining services in a self–directed manner, and (2) assure the appropriateness of such plans and budgets based upon a recipient's resources and capabilities. These measures must include (i) background studies, and (ii) backup and emergency plans, including disaster planning.

(b) The commissioner shall provide ongoing technical assistance and resource and educational materials for families and recipients selecting the self–directed option.

(c) Performance assessments measures, such as of a recipient's satisfaction with the services and supports, and ongoing monitoring of health and well–being shall be identified in consultation with the stakeholder group.

Subd. 10. **Fiscal support entity.** (a) Each recipient shall choose a fiscal support entity provider certified by the commissioner to make payments for services, items, supports, and administrative costs related to managing a self–directed service plan authorized for payment in the approved plan and budget. Recipients shall also choose the payroll, agency with choice, or the fiscal conduit model of financial and service management.

(b) The fiscal support entity:

(1) may not limit or restrict the recipient's choice of service or support providers, including use of the payroll, agency with choice, or fiscal conduit model of financial and service management;

(2) must have a written agreement with the recipient or the recipient's representative that identifies the duties and responsibilities to be performed and the specific related charges;

(3) must provide the recipient and the home care targeted case manager with a monthly written summary of the self–directed supports option services that were billed, including charges from the fiscal support entity;

(4) must be knowledgeable of and comply with Internal Revenue Service requirements necessary to process employer and employee deductions, provide appropriate and timely submission of employer tax liabilities, and maintain documentation to support medical assistance claims;

(5) must have current and adequate liability insurance and bonding and sufficient cash flow and have on staff or under contract a certified public accountant or an individual with a baccalaureate degree in accounting; and

(6) must maintain records to track all self–directed supports option services expenditures, including time records of persons paid to provide supports and receipts for any goods purchased. The records must be maintained for a minimum of five years from the claim date and be available for audit or review upon request. Claims submitted by the fiscal support entity must correspond with services, amounts, and time periods as authorized in the recipient's self–directed supports option plan.

(c) The commissioner shall have authority to:

(1) set or negotiate rates with fiscal support entities;

(2) limit the number of fiscal support entities;

(3) identify a process to certify and recertify fiscal support entities and assure fiscal support entities are available to recipients throughout the state; and

(4) establish a uniform format and protocol to be used by eligible fiscal support entities.

Subd. 11. **Stakeholder consultation.** The commissioner shall consult with a statewide consumer–directed services stakeholder group, including representatives of all types of consumer–directed service users, advocacy organizations, counties, and consumer–directed service providers. The commissioner shall seek recommendations from this stakeholder group in developing:

(1) the self–directed plan format;

(2) requirements and guidelines for the person–centered plan assessment and planning process;

(3) implementation of the option and the quality assurance and risk management techniques; and

(4) standards and requirements, including rates for the personal support plan development provider and the fiscal support entity; policies; training; and implementation. The stakeholder group shall provide recommendations on the repeal of the personal care assistant choice option, transition issues, and whether the consumer support grant program under section 256.476 should be modified. The stakeholder group shall meet at least three times each year to provide advice on policy, implementation, and other aspects of consumer and self–directed services.

History: *2007 c 147 art 7 s 12*

NOTE: Subdivisions 1 to 10 as added by Laws 2007, chapter 147, article 7, section 12, are effective upon federal approval of the state Medicaid plan amendment. Laws 2007, chapter 147, article 7, section 12, the effective date.

256B.0911 LONG–TERM CARE CONSULTATION SERVICES.

[For text of subds 1 to 3, see M.S.2006]

Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment, services planning, or other assistance intended to support community–based living, including persons who need assessment in order to determine waiver or alternative care program eligibility, must be visited by a long–term care consultation team within ten working days after

the date on which an assessment was requested or recommended. Assessments must be conducted according to paragraphs (b) to (i).

(b) The county may utilize a team of either the social worker or public health nurse, or both, to conduct the assessment in a face–to–face interview. The consultation team members must confer regarding the most appropriate care for each individual screened or assessed.

(c) The long–term care consultation team must assess the health and social needs of the person, using an assessment form provided by the commissioner.

(d) The team must conduct the assessment in a face–to–face interview with the person being assessed and the person's legal representative, if applicable.

(e) The team must provide the person, or the person's legal representative, with written recommendations for facility– or community–based services. The team must document that the most cost–effective alternatives available were offered to the individual. For purposes of this requirement, "cost–effective alternatives" means community services and living arrangements that cost the same as or less than nursing facility care.

(f) If the person chooses to use community–based services, the team must provide the person or the person's legal representative with a written community support plan, regardless of whether the individual is eligible for Minnesota health care programs. The person may request assistance in developing a community support plan without participating in a complete assessment.

(g) The person has the right to make the final decision between nursing facility placement and community placement after the screening team's recommendation, except as provided in subdivision 4a, paragraph (c).

(h) The team must give the person receiving assessment or support planning, or the person's legal representative, materials, and forms supplied by the commissioner containing the following information:

(1) the need for and purpose of preadmission screening if the person selects nursing facility placement;

(2) the role of the long–term care consultation assessment and support planning in waiver and alternative care program eligibility determination;

(3) information about Minnesota health care programs;

(4) the person's freedom to accept or reject the recommendations of the team;

(5) the person's right to confidentiality under the Minnesota Government Data Practices Act, chapter 13;

(6) the long–term care consultant's decision regarding the person's need for nursing facility level of care; and

(7) the person's right to appeal the decision regarding the need for nursing facility level of care or the county's final decisions regarding public programs eligibility according to section 256.045, subdivision 3.

(i) Face–to–face assessment completed as part of eligibility determination for the alternative care, elderly waiver, community alternatives for disabled individuals, community alternative care, and traumatic brain injury waiver programs under sections 256B.0915, 256B.0917, and 256B.49 is valid to establish service eligibility for no more than 60 calendar days after the date of assessment. The effective eligibility start date for these programs can never be prior to the date of assessment. If an assessment was completed more than 60 days before the effective waiver or alternative care program eligibility start date, assessment and support plan information must be updated in a face–to–face visit and documented in the department's Medicaid Management Information System (MMIS). The effective date of program eligibility in this case cannot be prior to the date the updated assessment is completed.

Subd. 3b. **Transition assistance.** (a) A long–term care consultation team shall provide assistance to persons residing in a nursing facility, hospital, regional treatment center, or intermediate care facility for persons with developmental disabilities who request or are referred for assistance. Transition assistance must include assessment, community support

plan development, referrals to Minnesota health care programs, and referrals to programs that provide assistance with housing. Transition assistance must also include information about the Centers for Independent Living and about other organizations that can provide assistance with relocation efforts, and information about contacting these organizations to obtain their assistance and support.

(b) The county shall develop transition processes with institutional social workers and discharge planners to ensure that:

(1) persons admitted to facilities receive information about transition assistance that is available;

(2) the assessment is completed for persons within ten working days of the date of request or recommendation for assessment; and

(3) there is a plan for transition and follow–up for the individual's return to the community. The plan must require notification of other local agencies when a person who may require assistance is screened by one county for admission to a facility located in another county.

(c) If a person who is eligible for a Minnesota health care program is admitted to a nursing facility, the nursing facility must include a consultation team member or the case manager in the discharge planning process.

Subd. 3c. **Transition to housing with services.** (a) Housing with services establishments offering or providing assisted living under chapter 144G shall inform all prospective residents of the availability of and contact information for transitional consultation services under this subdivision prior to executing a lease or contract with the prospective resident. The purpose of transitional long–term care consultation is to support persons with current or anticipated long–term care needs in making informed choices among options that include the most cost–effective and least restrictive settings, and to delay spenddown to eligibility for publicly funded programs by connecting people to alternative services in their homes before transition to housing with services. Regardless of the consultation, prospective residents maintain the right to choose housing with services or assisted living if that option is their preference.

(b) Transitional consultation services are provided as determined by the commissioner of human services in partnership with county long–term care consultation units, and the Area Agencies on Aging, and are a combination of telephone–based and in–person assistance provided under models developed by the commissioner. The consultation shall be performed in a manner that provides objective and complete information. Transitional consultation must be provided within five working days of the request of the prospective resident as follows:

(1) the consultation must be provided by a qualified professional as determined by the commissioner;

(2) the consultation must include a review of the prospective resident's reasons for considering assisted living, the prospective resident's personal goals, a discussion of the prospective resident's immediate and projected long–term care needs, and alternative community services or assisted living settings that may meet the prospective resident's needs; and

(3) the prospective resident shall be informed of the availability of long–term care consultation services described in subdivision 3a that are available at no charge to the prospective resident to assist the prospective resident in assessment and planning to meet the prospective resident's long–term care needs.

[For text of subd 4a, see M.S.2006]

Subd. 4b. **Exemptions and emergency admissions.** (a) Exemptions from the federal screening requirements outlined in subdivision 4a, paragraphs (b) and (c), are limited to:

(1) a person who, having entered an acute care facility from a certified nursing facility, is returning to a certified nursing facility;

(2) a person transferring from one certified nursing facility in Minnesota to another certified nursing facility in Minnesota; and

(3) a person, 21 years of age or older, who satisfies the following criteria, as specified in Code of Federal Regulations, title 42, section 483.106(b)(2):

(i) the person is admitted to a nursing facility directly from a hospital after receiving acute inpatient care at the hospital;

(ii) the person requires nursing facility services for the same condition for which care was provided in the hospital; and

(iii) the attending physician has certified before the nursing facility admission that the person is likely to receive less than 30 days of nursing facility services.

(b) Persons who are exempt from preadmission screening for purposes of level of care determination include:

(1) persons described in paragraph (a);

(2) an individual who has a contractual right to have nursing facility care paid for indefinitely by the veterans' administration;

(3) an individual enrolled in a demonstration project under section 256B.69, subdivision 8, at the time of application to a nursing facility; and

(4) an individual currently being served under the alternative care program or under a home and community–based services waiver authorized under section 1915(c) of the federal Social Security Act.

(c) Persons admitted to a Medicaid–certified nursing facility from the community on an emergency basis as described in paragraph (d) or from an acute care facility on a nonworking day must be screened the first working day after admission.

(d) Emergency admission to a nursing facility prior to screening is permitted when all of the following conditions are met:

(1) a person is admitted from the community to a certified nursing or certified boarding care facility during county nonworking hours;

(2) a physician has determined that delaying admission until preadmission screening is completed would adversely affect the person's health and safety;

(3) there is a recent precipitating event that precludes the client from living safely in the community, such as sustaining an injury, sudden onset of acute illness, or a caregiver's inability to continue to provide care;

(4) the attending physician has authorized the emergency placement and has documented the reason that the emergency placement is recommended; and

(5) the county is contacted on the first working day following the emergency admission.

Transfer of a patient from an acute care hospital to a nursing facility is not considered an emergency except for a person who has received hospital services in the following situations: hospital admission for observation, care in an emergency room without hospital admission, or following hospital 24–hour bed care.

(e) A nursing facility must provide written information to all persons admitted regarding the person's right to request and receive long–term care consultation services as defined in subdivision 1a. The information must be provided prior to the person's discharge from the facility and in a format specified by the commissioner.

Subd. 4c. **Screening requirements.** (a) A person may be screened for nursing facility admission by telephone or in a face–to–face screening interview. Consultation team members shall identify each individual's needs using the following categories:

(1) the person needs no face–to–face screening interview to determine the need for nursing facility level of care based on information obtained from other health care professionals;

(2) the person needs an immediate face–to–face screening interview to determine the need for nursing facility level of care and complete activities required under subdivision 4a; or

(3) the person may be exempt from screening requirements as outlined in subdivision 4b, but will need transitional assistance after admission or in–person follow–along after a return home.

(b) Persons admitted on a nonemergency basis to a Medicaid–certified nursing facility must be screened prior to admission.

(c) The county screening or intake activity must include processes to identify persons who may require transition assistance as described in subdivision 3b.

[For text of subds 4d and 5, see M.S.2006]

Subd. 6. **Payment for long–term care consultation services.** (a) The total payment for each county must be paid monthly by certified nursing facilities in the county. The monthly amount to be paid by each nursing facility for each fiscal year must be determined by dividing the county's annual allocation for long–term care consultation services by 12 to determine the monthly payment and allocating the monthly payment to each nursing facility based on the number of licensed beds in the nursing facility. Payments to counties in which there is no certified nursing facility must be made by increasing the payment rate of the two facilities located nearest to the county seat.

(b) The commissioner shall include the total annual payment determined under paragraph (a) for each nursing facility reimbursed under section 256B.431 or 256B.434 according to section 256B.431, subdivision 2b, paragraph (g).

(c) In the event of the layaway, delicensure and decertification, or removal from layaway of 25 percent or more of the beds in a facility, the commissioner may adjust the per diem payment amount in paragraph (b) and may adjust the monthly payment amount in paragraph (a). The effective date of an adjustment made under this paragraph shall be on or after the first day of the month following the effective date of the layaway, delicensure and decertification, or removal from layaway.

(d) Payments for long–term care consultation services are available to the county or counties to cover staff salaries and expenses to provide the services described in subdivision 1a. The county shall employ, or contract with other agencies to employ, within the limits of available funding, sufficient personnel to provide long–term care consultation services while meeting the state's long–term care outcomes and objectives as defined in section 256B.0917, subdivision 1. The county shall be accountable for meeting local objectives as approved by the commissioner in the biennial home and community–based services quality assurance plan on a form provided by the commissioner.

(e) Notwithstanding section 256B.0641, overpayments attributable to payment of the screening costs under the medical assistance program may not be recovered from a facility.

(f) The commissioner of human services shall amend the Minnesota medical assistance plan to include reimbursement for the local consultation teams.

(g) The county may bill, as case management services, assessments, support planning, and follow–along provided to persons determined to be eligible for case management under Minnesota health care programs. No individual or family member shall be charged for an initial assessment or initial support plan development provided under subdivision 3a or 3b.

Subd. 6a. **Withholding.** If any provider obligated to pay the long–term care consultation amount as described in subdivision 6 is more than two months delinquent in the timely payment of the monthly installment, the commissioner may withhold payments, penalties, and interest in accordance with the methods outlined in section 256.9657, subdivision 7a. Any amount withheld under this provision must be returned to the county to whom the delinquent payments were due.

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 county 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 crite-

ria for nursing facility placement or, if indicated, has not had a level II OBRA evaluation as required under the federal Omnibus Budget Reconciliation Act of 1987 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 developmental disability is approved by the state developmental disability authority.

(b) The nursing facility must not bill a person who is not a medical assistance recipient for resident days that preceded the date of completion of screening activities as required under subdivisions 4a, 4b, and 4c. The nursing facility must include unreimbursed resident days in the nursing facility resident day totals reported to the commissioner.

History: *2007 c 147 art 6 s 23–28; art 7 s 13,14*

NOTE: Subdivision 3c as added by Laws 2007, chapter 147, article 7, section 14, is effective October 1, 2008. Laws 2007, chapter 147, article 7, section 14, the effective date.

256B.0913 ALTERNATIVE CARE PROGRAM.

[For text of subds 1 and 2, see M.S.2006]

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

(1) the person has been determined by a community assessment under section 256B.0911 to be a person who would require the level of care provided in a nursing facility, but for the provision of services under the alternative care program;

(2) the person is age 65 or older;

(3) the person would be eligible for medical assistance within 135 days of admission to a nursing facility;

(4) the person is not ineligible for the payment of long–term care services by the medical assistance program due to an asset transfer penalty under section 256B.0595 or equity interest in the home exceeding $500,000 as stated in section 256B.056;

(5) the person needs long–term care services that are not funded through other state or federal funding;

(6) the monthly cost of the alternative care services funded by the program for this person does not exceed 75 percent of the monthly limit described under section 256B.0915, subdivision 3a. This monthly limit does not prohibit the alternative care client from payment for additional services, but in no case may the cost of additional services purchased under this section exceed the difference between the client's monthly service limit defined under section 256B.0915, subdivision 3, and the alternative care program monthly service limit defined in this paragraph. If care–related supplies and equipment or environmental modifications and adaptations are or will be purchased for an alternative care services recipient, the costs may be prorated on a monthly basis for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's other alternative care services exceeds the monthly limit established in this paragraph, the annual cost of the alternative care services shall be determined. In this event, the annual cost of alternative care services shall not exceed 12 times the monthly limit described in this paragraph; and

(7) the person is making timely payments of the assessed monthly fee.

A person is ineligible if payment of the fee is over 60 days past due, unless the person agrees to:

(i) the appointment of a representative payee;

(ii) automatic payment from a financial account;

(iii) the establishment of greater family involvement in the financial management of payments; or

(iv) another method acceptable to the lead agency to ensure prompt fee payments.

The lead agency may extend the client's eligibility as necessary while making arrangements to facilitate payment of past–due amounts and future premium payments. Following

disenrollment due to nonpayment of a monthly fee, eligibility shall not be reinstated for a period of 30 days.

(b) Alternative care funding under this subdivision is not available for a person who is a medical assistance recipient or who would be eligible for medical assistance without a spenddown or waiver obligation. A person whose initial application for medical assistance and the elderly waiver program is being processed may be served under the alternative care program for a period up to 60 days. If the individual is found to be eligible for medical assistance, medical assistance must be billed for services payable under the federally approved elderly waiver plan and delivered from the date the individual was found eligible for the federally approved elderly waiver plan. Notwithstanding this provision, alternative care funds may not be used to pay for any service the cost of which: (i) is payable by medical assistance; (ii) is used by a recipient to meet a waiver obligation; or (iii) is used to pay a medical assistance income spenddown for a person who is eligible to participate in the federally approved elderly waiver program under the special income standard provision.

(c) Alternative care funding is not available for a person who resides in a licensed nursing home, certified boarding care home, hospital, or intermediate care facility, except for case management services which are provided in support of the discharge planning process for a nursing home resident or certified boarding care home resident to assist with a relocation process to a community–based setting.

(d) Alternative care funding is not available for a person whose income is greater than the maintenance needs allowance under section 256B.0915, subdivision 1d, but equal to or less than 120 percent of the federal poverty guideline effective July 1 in the fiscal year for which alternative care eligibility is determined, who would be eligible for the elderly waiver with a waiver obligation.

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

(1) adult day care;

(2) home health aide;

(3) homemaker services;

(4) personal care;

(5) case management;

(6) respite care;

(7) care–related supplies and equipment;

(8) meals delivered to the home;

(9) nonmedical transportation;

(10) nursing services;

(11) chore services;

(12) companion services;

(13) nutrition services;

(14) training for direct informal caregivers;

(15) telehome care to provide services in their own homes in conjunction with in–home visits;

(16) consumer–directed community services under the alternative care programs which are available statewide and limited to the average monthly expenditures representative of all alternative care program participants for the same case mix resident class assigned in the most recent fiscal year for which complete expenditure data is available;

(17) environmental modifications and adaptations; and

(18) discretionary services, for which lead agencies may make payment from their alternative care program allocation for services not otherwise defined in this section or section 256B.0625, following approval by the commissioner.

Total annual payments for discretionary services for all clients served by a lead agency must not exceed 25 percent of that lead agency's annual alternative care program base allocation.

Subd. 5a. **Services; service definitions; service standards.** (a) Unless specified in statute, the services, service definitions, and standards for alternative care services shall be the same as the services, service definitions, and standards specified in the federally approved elderly waiver plan, except alternative care does not cover transitional support services, assisted living services, adult foster care services, and residential care and benefits defined under section 256B.0625 that meet primary and acute health care needs.

(b) The lead agency must ensure that the funds are not used to supplant or supplement services available through other public assistance or services programs, including supplementation of client co–pays, deductibles, premiums, or other cost–sharing arrangements for health–related benefits and services or entitlement programs and services that are available to the person, but in which they have elected not to enroll. For a provider of supplies and equipment when the monthly cost of the supplies and equipment is less than $250, persons or agencies must be employed by or under a contract with the lead agency or the public health nursing agency of the local board of health in order to receive funding under the alternative care program. Supplies and equipment may be purchased from a vendor not certified to participate in the Medicaid program if the cost for the item is less than that of a Medicaid vendor.

(c) Personal care services must meet the service standards defined in the federally approved elderly waiver plan, except that a lead agency may contract with a client's relative who meets the relative hardship waiver requirements or a relative who meets the criteria and is also the responsible party under an individual service plan that ensures the client's health and safety and supervision of the personal care services by a qualified professional as defined in section 256B.0625, subdivision 19c. Relative hardship is established by the lead agency when the client's care causes a relative caregiver to do any of the following: resign from a paying job, reduce work hours resulting in lost wages, obtain a leave of absence resulting in lost wages, incur substantial client–related expenses, provide services to address authorized, unstaffed direct care time, or meet special needs of the client unmet in the formal service plan.

Subd. 5b. [Repealed, 2007 c 147 art 7 s 76]

Subd. 5c. [Repealed, 2007 c 147 art 7 s 76]

Subd. 5d. [Repealed, 2007 c 147 art 7 s 76]

Subd. 5e. [Repealed, 2007 c 147 art 7 s 76]

Subd. 5f. [Repealed, 2007 c 147 art 7 s 76]

Subd. 5g. [Repealed, 2007 c 147 art 7 s 76]

Subd. 5h. [Repealed, 2007 c 147 art 7 s 76]

[For text of subds 5i to 7, see M.S.2006]

Subd. 8. **Requirements for individual care plan.** (a) The case manager shall implement the plan of care for each alternative care client and ensure that a client's service needs and eligibility are reassessed at least every 12 months. The plan shall include any services prescribed by the individual's attending physician as necessary to allow the individual to remain in a community setting. In developing the individual's care plan, the case manager should include the use of volunteers from families and neighbors, religious organizations, social clubs, and civic and service organizations to support the formal home care services. The lead agency shall be held harmless for damages or injuries sustained through the use of volunteers under this subdivision including workers' compensation liability. The case manager shall provide documentation in each individual's plan of care and, if requested, to the commissioner that the most cost–effective alternatives available have been offered to the individual and that the individual was free to choose among available qualified providers, both public and private, including qualified case management or service coordination providers other than those employed by any county; however, the county or tribe maintains responsi-

bility for prior authorizing services in accordance with statutory and administrative requirements. The case manager must give the individual a ten–day written notice of any denial, termination, or reduction of alternative care services.

(b) The county of service or tribe must provide access to and arrange for case management services, including assuring implementation of the plan. "County of service" has the meaning given it in Minnesota Rules, part 9505.0015, subpart 11. The county of service must notify the county of financial responsibility of the approved care plan and the amount of encumbered funds.

Subd. 9. **Contracting provisions for providers.** Alternative care funds paid to service providers are subject to audit by the commissioner for fiscal and utilization control.

The lead agency must select providers for contracts or agreements using the following criteria and other criteria established by the lead agency:

(1) the need for the particular services offered by the provider;

(2) the population to be served, including the number of clients, the length of time services will be provided, and the medical condition of clients;

(3) the geographic area to be served;

(4) quality assurance methods, including appropriate licensure, certification, or standards, and supervision of employees when needed;

(5) rates for each service and unit of service exclusive of lead agency administrative costs;

(6) evaluation of services previously delivered by the provider; and

(7) contract or agreement conditions, including billing requirements, cancellation, and indemnification.

The lead agency must evaluate its own agency services under the criteria established for other providers.

Subd. 10. **Allocation formula.** (a) By July 15 of each year, the commissioner shall allocate to county agencies the state funds available for alternative care for persons eligible under subdivision 2.

(b) The adjusted base for each lead agency is the lead agency's current fiscal year base allocation plus any targeted funds approved during the current fiscal year. Calculations for paragraphs (c) and (d) are to be made as follows: for each lead agency, the determination of alternative care program expenditures shall be based on payments for services rendered from April 1 through March 31 in the base year, to the extent that claims have been submitted and paid by June 1 of that year.

(c) If the alternative care program expenditures as defined in paragraph (b) are 95 percent or more of the lead agency's adjusted base allocation, the allocation for the next fiscal year is 100 percent of the adjusted base, plus inflation to the extent that inflation is included in the state budget.

(d) If the alternative care program expenditures as defined in paragraph (b) are less than 95 percent of the lead agency's adjusted base allocation, the allocation for the next fiscal year is the adjusted base allocation less the amount of unspent funds below the 95 percent level.

(e) If the annual legislative appropriation for the alternative care program is inadequate to fund the combined lead agency allocations for a biennium, the commissioner shall distribute to each lead agency the entire annual appropriation as that lead agency's percentage of the computed base as calculated in paragraphs (c) and (d).

(f) On agreement between the commissioner and the lead agency, the commissioner may have discretion to reallocate alternative care base allocations distributed to lead agencies in which the base amount exceeds program expenditures.

Subd. 11. **Targeted funding.** (a) The purpose of targeted funding is to make additional money available to lead agencies with the greatest need. Targeted funds are not intended to be

distributed equitably among all lead agencies, but rather, allocated to those with long-term care strategies that meet state goals.

(b) The funds available for targeted funding shall be the total appropriation for each fiscal year minus lead agency allocations determined under subdivision 10 as adjusted for any inflation increases provided in appropriations for the biennium.

(c) The commissioner shall allocate targeted funds to lead agencies that demonstrate to the satisfaction of the commissioner that they have developed feasible plans to increase alternative care spending. In making targeted funding allocations, the commissioner shall use the following priorities:

(1) lead agencies that received a lower allocation in fiscal year 1991 than in fiscal year 1990. Counties remain in this priority until they have been restored to their fiscal year 1990 level plus inflation;

(2) lead agencies that sustain a base allocation reduction for failure to spend 95 percent of the allocation if they demonstrate that the base reduction should be restored;

(3) lead agencies that propose projects to divert community residents from nursing home placement or convert nursing home residents to community living; and

(4) lead agencies that can otherwise justify program growth by demonstrating the existence of waiting lists, demographically justified needs, or other unmet needs.

(d) Lead agencies that would receive targeted funds according to paragraph (c) must demonstrate to the commissioner's satisfaction that the funds would be appropriately spent by showing how the funds would be used to further the state's alternative care goals as described in subdivision 1, and that the county has the administrative and service delivery capability to use them.

(e) The commissioner shall make applications available for targeted funds by November 1 of each year. The lead agencies selected for targeted funds shall be notified of the amount of their additional funding. Targeted funds allocated to a lead agency in one year shall be treated as part of the lead agency's base allocation for that year in determining allocations for subsequent years. No reallocations between lead agencies shall be made.

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

(1) when the alternative care client's income less recurring and predictable medical expenses is less than 100 percent of the federal poverty guideline effective on July 1 of the state fiscal year in which the fee is being computed, and total assets are less than $10,000, the fee is zero;

(2) when the alternative care client's income less recurring and predictable medical expenses is equal to or greater than 100 percent but less than 150 percent of the federal poverty guideline effective on July 1 of the state fiscal year in which the fee is being computed, and total assets are less than $10,000, the fee is five percent of the cost of alternative care services;

(3) when the alternative care client's income less recurring and predictable medical expenses is equal to or greater than 150 percent but less than 200 percent of the federal poverty guidelines effective on July 1 of the state fiscal year in which the fee is being computed and assets are less than $10,000, the fee is 15 percent of the cost of alternative care services;

(4) when the alternative care client's income less recurring and predictable medical expenses is equal to or greater than 200 percent of the federal poverty guidelines effective on July 1 of the state fiscal year in which the fee is being computed and assets are less than $10,000, the fee is 30 percent of the cost of alternative care services; and

(5) when the alternative care client's assets are equal to or greater than $10,000, the fee is 30 percent of the cost of alternative care services.

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

All alternative care services shall be included in the estimated costs for the purpose of determining the fee.

Fees are due and payable each month alternative care services are received unless the actual cost of the services is less than the fee, in which case the fee is the lesser amount.

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

(1) a person is residing in a nursing facility;

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

(3) a person is found eligible for alternative care, but is not yet receiving alternative care services including case management services; or

(4) a person has chosen to participate in a consumer–directed service plan for which the cost is no greater than the total cost of the person's alternative care service plan less the monthly fee amount that would otherwise be assessed.

(c) The commissioner will bill and collect the fee from the client. Money collected must be deposited in the general fund and is appropriated to the commissioner for the alternative care program. The client must supply the lead agency with the client's Social Security number at the time of application. The lead agency shall supply the commissioner with the client's Social Security number and other information the commissioner requires to collect the fee from the client. The commissioner shall collect unpaid fees using the Revenue Recapture Act in chapter 270A and other methods available to the commissioner. The commissioner may require lead agencies to inform clients of the collection procedures that may be used by the state if a fee is not paid. This paragraph does not apply to alternative care pilot projects authorized in Laws 1993, First Special Session chapter 1, article 5, section 133, if a county operating under the pilot project reports the following dollar amounts to the commissioner quarterly:

(1) total fees billed to clients;

(2) total collections of fees billed; and

(3) balance of fees owed by clients.

If a lead agency does not adhere to these reporting requirements, the commissioner may terminate the billing, collecting, and remitting portions of the pilot project and require the lead agency involved to operate under the procedures set forth in this paragraph.

Subd. 13. **Lead agency biennial plan.** The lead agency biennial plan for long–term care consultation services under section 256B.0911, the alternative care program under this section, and waivers for the elderly under section 256B.0915, shall be submitted by the lead agency as the home and community–based services quality assurance plan on a form provided by the commissioner.

Subd. 14. **Provider requirements, payment, and rate adjustments.** (a) Unless otherwise specified in statute, providers must be enrolled as Minnesota health care program providers and abide by the requirements for provider participation according to Minnesota Rules, part 9505.0195.

(b) Payment for provided alternative care services as approved by the client's case manager shall occur through the invoice processing procedures of the department's Medicaid Management Information System (MMIS). To receive payment, the lead agency or vendor must submit invoices within 12 months following the date of service. The lead agency and its vendors under contract shall not be reimbursed for services which exceed the county allocation.

(c) The lead agency shall negotiate individual rates with vendors and may authorize service payment for actual costs up to the county's current approved rate. 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. To improve access to community services and eliminate payment disparities between the alternative care program and the elderly waiver program, the commissioner shall establish statewide maximum service rate limits and eliminate county–specific service rate limits.

(1) Effective July 1, 2001, for service rate limits, except those in subdivision 5, paragraphs (d) and (i), the rate limit for each service shall be the greater of the alternative care statewide maximum rate or the elderly waiver statewide maximum rate.

(2) Lead agencies may negotiate individual service rates with vendors for actual costs up to the statewide maximum service rate limit.

History: *2007 c 147 art 6 s 29–38*

256B.0915 MEDICAID WAIVER FOR ELDERLY SERVICES.

Subdivision 1. **Authority.** The commissioner is authorized to apply for a home and community–based services waiver for the elderly, authorized under section 1915(c) of the Social Security Act, in order to obtain federal financial participation to expand the availability of services for persons who are eligible for medical assistance. The commissioner may apply for additional waivers or pursue other federal financial participation which is advantageous to the state for funding home care services for the frail elderly who are eligible for medical assistance. The provision of waivered services to elderly and disabled medical assistance recipients must comply with the criteria for service definitions and provider standards approved in the waiver.

Subd. 1a. **Elderly waiver case management services.** (a) Elderly case management services under the home and community–based services waiver for elderly individuals are available from providers meeting qualification requirements and the standards specified in subdivision 1b. Eligible recipients may choose any qualified provider of elderly case management services.

Case management services assist individuals who receive waiver services in gaining access to needed waiver and other state plan services, as well as needed medical, social, educational, and other services regardless of the funding source for the services to which access is gained.

A case aide shall provide assistance to the case manager in carrying out administrative activities of the case management function. The case aide may not assume responsibilities that require professional judgment including assessments, reassessments, and care plan development. The case manager is responsible for providing oversight of the case aide.

Case managers shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care. Case managers shall initiate and oversee the process of assessment and reassessment of the individual's care and review plan of care at intervals specified in the federally approved waiver plan.

(b) The county of service or tribe must provide access to and arrange for case management services. County of service has the meaning given it in Minnesota Rules, part 9505.0015, subpart 11.

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 lead agency may allow a case manager employed by the lead agency to delegate certain aspects of the case management activity to another individual employed by the lead agency 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. Lead agencies include counties, health plans, and federally recognized tribes who authorize services under this section.

Subd. 1c. [Repealed by amendment, 2007 c 147 art 7 s 15]

Subd. 1d. **Posteligibility treatment of income and resources for elderly waiver.** Notwithstanding the provisions of section 256B.056, the commissioner shall make the following amendment to the medical assistance elderly waiver program effective July 1, 1999, 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. Recipient maintenance needs shall be adjusted under this provision each July 1.

Subd. 2. **Spousal impoverishment policies.** The commissioner shall apply:

(1) the spousal impoverishment criteria as authorized under United States Code, title 42, section 1396r–5, and as implemented in sections 256B.0575, 256B.058, and 256B.059;

(2) the personal needs allowance permitted in section 256B.0575; and

(3) an amount equivalent to the group residential housing rate as set by section 256I.03, subdivision 5, and according to the approved federal waiver and medical assistance state plan.

Subd. 3. **Limits of cases.** The number of medical assistance waiver recipients that a lead agency 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.

Subd. 3a. **Elderly waiver cost limits.** (a) The monthly limit for the cost of waivered services to an individual elderly waiver client shall be the weighted average monthly nursing facility rate of the case mix resident class to which the elderly waiver client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the recipient's maintenance needs allowance as described in subdivision 1d, paragraph (a), until the first day of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented. Effective on the first day of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented and the first day of each subsequent state fiscal year, the monthly limit for the cost of waivered services to an individual elderly waiver client shall be the rate of the case mix resident class to which the waiver client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, in effect on the last day of the previous state fiscal year, adjusted by the greater of any legislatively adopted home and community–based services percentage rate increase or the average statewide percentage increase in nursing facility payment rates.

(b) If extended medical supplies and equipment or environmental modifications are or will be purchased for an elderly waiver client, the costs may be prorated for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's waivered services exceeds the monthly limit established in paragraph (a), the annual cost of all waivered services shall be determined. In this event, the annual cost of all waivered services shall not exceed 12 times the monthly limit of waivered services as described in paragraph (a).

Subd. 3b. **Cost limits for elderly waiver applicants who reside in a nursing facility.** (a) For a person who is a nursing facility resident at the time of requesting a determination of

eligibility for elderly waivered services, a monthly conversion limit for the cost of elderly waivered services may be requested. The monthly conversion limit for the cost of elderly waiver services shall be 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 until July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented. Effective on July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented, the monthly conversion limit for the cost of elderly waiver services shall be the per diem nursing facility rate as determined by the resident assessment system as described in section 256B.438 for that resident in the nursing facility where the resident currently resides multiplied by 365 and divided by 12, less the recipient's maintenance needs allowance as described in subdivision 1d. The initially approved conversion rate may be adjusted by the greater of any subsequent legislatively adopted home and community–based services percentage rate increase or the average statewide percentage increase in nursing facility payment rates. The limit under this subdivision only applies to persons discharged from a nursing facility after a minimum 30–day stay and found eligible for waivered services on or after July 1, 1997. For conversions from the nursing home to the elderly waiver with consumer directed community support services, the conversion rate limit is equal to the nursing facility rate reduced by a percentage equal to the percentage difference between the consumer directed services budget limit that would be assigned according to the federally approved waiver plan and the corresponding community case mix cap, but not to exceed 50 percent.

(b) 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 environmental modifications and adaptations; and

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

Subd. 3c. **Service approval and contracting provisions.** (a) 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.

(b) A lead agency 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.

Subd. 3d. **Adult foster care rate.** The adult foster care rate shall be considered a difficulty of care payment and shall not include room and board. The adult foster care service rate shall be negotiated between the lead agency and the foster care provider. The elderly waiver payment for the foster care service in combination with the payment for all other elderly waiver services, including case management, must not exceed the limit specified in subdivision 3a, paragraph (a).

Subd. 3e. **Customized living service rate.** (a) Payment for customized living services shall be a monthly rate negotiated and authorized by the lead agency within the parameters established by the commissioner. The payment agreement must delineate the services that have been customized for each recipient and specify the amount of each service to be provided. The lead agency shall ensure that there is a documented need for all services authorized. Customized living services must not include rent or raw food costs. The negotiated payment rate must be based on services to be provided. Negotiated rates must not exceed payment rates for comparable elderly waiver or medical assistance services and must reflect economies of scale.

(b) The individualized monthly negotiated payment for customized living services shall not exceed the nonfederal share, in effect on July 1 of the state fiscal year for which the rate limit is being calculated, of the greater of either the statewide or any of the geographic groups' weighted average monthly nursing facility rate of the case mix resident class to which the elderly waiver eligible client would be assigned under Minnesota Rules, parts

9549.0050 to 9549.0059, less the maintenance needs allowance as described in subdivision 1d, paragraph (a), until the July 1 of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented. Effective on July 1 of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented and July 1 of each subsequent state fiscal year, the individualized monthly negotiated payment for the services described in this clause shall not exceed the limit described in this clause which was in effect on June 30 of the previous state fiscal year and which has been adjusted by the greater of any legislatively adopted home and community-based services cost-of-living percentage increase or any legislatively adopted statewide percent rate increase for nursing facilities.

(c) Customized living services are delivered by a provider licensed by the Department of Health as a class A or class F home care provider and provided in a building that is registered as a housing with services establishment under chapter 144D.

Subd. 3f. **Individual service rates; expenditure forecasts.** (a) The lead agency shall negotiate individual service rates with vendors and may authorize payment for actual costs up to the lead agency's current approved rate. Persons or agencies must be employed by or under a contract with the lead agency or the public health nursing agency of the local board of health in order to receive funding under the elderly waiver program, except as a provider of supplies and equipment when the monthly cost of the supplies and equipment is less than $250.

(b) 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.

Subd. 3g. **Service rate limits; state assumption of costs.** (a) To improve access to community services and eliminate payment disparities between the alternative care program and the elderly waiver, the commissioner shall establish statewide maximum service rate limits and eliminate lead agency-specific service rate limits.

(b) Effective July 1, 2001, for service rate limits, except those described or defined in subdivisions 3d and 3e, the rate limit for each service shall be the greater of the alternative care statewide maximum rate or the elderly waiver statewide maximum rate.

(c) Lead agencies may negotiate individual service rates with vendors for actual costs up to the statewide maximum service rate limit.

Subd. 3h. **Service rate limits; 24-hour customized living services.** The payment rates for 24-hour customized living services is a monthly rate negotiated and authorized by the lead agency within the parameters established by the commissioner of human services. The payment agreement must delineate the services that have been customized for each recipient and specify the amount of each service to be provided. The lead agency shall ensure that there is a documented need for all services authorized. The lead agency shall not authorize 24-hour customized living services unless there is a documented need for 24-hour supervision. For purposes of this section, "24-hour supervision" means that the recipient requires assistance due to needs related to one or more of the following:

(1) intermittent assistance with toileting or transferring;

(2) cognitive or behavioral issues;

(3) a medical condition that requires clinical monitoring; or

(4) other conditions or needs as defined by the commissioner of human services. The lead agency shall ensure that the frequency and mode of supervision of the recipient and the qualifications of staff providing supervision are described and meet the needs of the recipient. Customized living services must not include rent or raw food costs. The negotiated payment rate for 24-hour customized living services must be based on services to be provided.

Negotiated rates must not exceed payment rates for comparable elderly waiver or medical assistance services and must reflect economies of scale. The individually negotiated 24–hour customized living payments, in combination with the payment for other elderly waiver services, including case management, must not exceed the recipient's community budget cap specified in subdivision 3a.

Subd. 4. **Termination notice.** The case manager must give the individual a ten–day written notice of any denial, reduction, or termination of waivered services.

Subd. 5. **Assessments and reassessments for waiver clients.** Each client shall receive an initial assessment of strengths, informal supports, and need for services in accordance with section 256B.0911, subdivisions 3, 3a, and 3b. A reassessment of a client served under the elderly waiver must be conducted at least every 12 months and at other times when the case manager determines that there has been significant change in the client's functioning. This may include instances where the client is discharged from the hospital.

Subd. 6. **Implementation of care plan.** Each elderly waiver client shall be provided a copy of a written care plan that meets the requirements outlined in section 256B.0913, subdivision 8. The care plan must be implemented by the county of service when it is different than the county of financial responsibility. The county of service administering waivered services must notify the county of financial responsibility of the approved care plan.

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 also receive county–administered elderly waiver services.

Subd. 8. **Services and supports.** (a) Services and supports shall meet the requirements set out in United States Code, title 42, section 1396n.

(b) Services and supports shall promote consumer choice and be arranged and provided consistent with individualized, written care plans.

(c) The state of Minnesota, county, managed care organization, or tribal government under contract to administer the elderly waiver shall not be liable for damages, injuries, or liabilities sustained through the purchase of direct supports or goods by the person, the person's family, or the authorized representatives with funds received through consumer–directed community support services under the federally approved waiver plan. Liabilities include, but are not limited to, workers' compensation liability, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA).

Subd. 9. **Tribal management of elderly waiver.** Notwithstanding contrary provisions of this section, or those in other state laws or rules, the commissioner may develop a model for tribal management of the elderly waiver program and implement this model through a contract between the state and any of the state's federally recognized tribal governments. The model shall include the provision of tribal waiver case management, assessment for personal care assistance, and administrative requirements otherwise carried out by lead agencies but shall not include tribal financial eligibility determination for medical assistance.

History: *2007 c 147 art 7 s 15*

256B.0919 ADULT FOSTER CARE AND FAMILY ADULT DAY CARE.

[For text of subds 1 and 2, see M.S.2006]

Subd. 3. **County certification of persons providing adult foster care to related persons.** A person exempt from licensure under section 245A.03, subdivision 2, who provides adult foster care to a related individual age 65 and older, and who meets the requirements in Minnesota Rules, parts 9555.5105 to 9555.6265, may be certified by the county to provide adult foster care. A person certified by the county to provide adult foster care may be reimbursed for services provided and eligible for funding under section 256B.0915, if the relative would suffer a financial hardship as a result of providing care. For purposes of this subdivision, financial hardship refers to a situation in which a relative incurs a substantial reduction

in income as a result of resigning from a full–time job or taking a leave of absence without pay from a full–time job to care for the client.

Subd. 4. **County certification; licensed providers; related individual; developmentally disabled.** (a) Notwithstanding any provision to the contrary, a county may certify an adult foster care license holder to provide foster care services to an individual with a developmental disability, who is related to the provider, if the following conditions are met:

(1) the individual is 18 years of age or older;

(2) the individual's service plan meets the standards of section 256B.092 and specifies any special conditions necessary to prevent a conflict of interest for the provider;

(3) the provider is not the legal guardian or conservator of the related individual;

(4) the provider maintains a license under Minnesota Rules, parts 9555.5105 to 9555.6265, to serve unrelated foster care recipients;

(5) the provider maintains a license under chapter 245B; and

(6) the county certifies the provider meets the adult foster care provider standards established in Minnesota Rules, parts 9555.5105 to 9555.6265, for services provided to the related individual.

(b) The county shall complete an annual certification review to ensure compliance with paragraph (a), clauses (1) to (6).

(c) Notwithstanding section 256I.04, subdivision 2a, clause (2), the adult foster care provider certified by the county under this subdivision may be reimbursed for room and board costs through the group residential housing program.

History: *2007 c 112 s 49; 2007 c 147 art 6 s 39*

256B.092 SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES.

[For text of subds 1 to 4c, see M.S.2006]

Subd. 4d. **Medicaid reimbursement; licensed provider; related individuals.** The commissioner shall seek a federal amendment to the home and community–based services waiver for individuals with developmental disabilities, to allow Medicaid reimbursement for the provision of supported living services to a related individual when the following conditions have been met:

(1) the individual is 18 years of age or older;

(2) the provider is certified initially and annually thereafter, by the county, as meeting the provider standards established in chapter 245B and the federal waiver plan;

(3) the provider has been certified by the county as meeting the adult foster care provider standards established in Minnesota Rules, parts 9555.5105 to 9555.6265;

(4) the provider is not the legal guardian or conservator of the related individual; and

(5) the individual's service plan meets the standards of section 256B.092 and specifies any special conditions necessary to prevent a conflict of interest for the provider.

[For text of subds 5 to 10, see M.S.2006]

History: *2007 c 112 s 50*

256B.0943 CHILDREN'S THERAPEUTIC SERVICES AND SUPPORTS.

[For text of subds 1 to 5, see M.S.2006]

Subd. 6. **Provider entity clinical infrastructure requirements.** (a) To be an eligible provider entity under this section, a provider entity must have a clinical infrastructure that utilizes diagnostic assessment, an individualized treatment plan, service delivery, and individual treatment plan review that are culturally competent, child–centered, and family–driven to achieve maximum benefit for the client. The provider entity must review and update the

clinical policies and procedures every three years and must distribute the policies and procedures to staff initially and upon each subsequent update.

(b) The clinical infrastructure written policies and procedures must include policies and procedures for:

(1) providing or obtaining a client's diagnostic assessment that identifies acute and chronic clinical disorders, co–occurring medical conditions, sources of psychological and environmental problems, and a functional assessment. The functional assessment must clearly summarize the client's individual strengths and needs;

(2) developing an individual treatment plan that is:

(i) based on the information in the client's diagnostic assessment;

(ii) developed no later than the end of the first psychotherapy session after the completion of the client's diagnostic assessment by the mental health professional who provides the client's psychotherapy;

(iii) developed through a child–centered, family–driven planning process that identifies service needs and individualized, planned, and culturally appropriate interventions that contain specific treatment goals and objectives for the client and the client's family or foster family;

(iv) reviewed at least once every 90 days and revised, if necessary; and

(v) signed by the client or, if appropriate, by the client's parent or other person authorized by statute to consent to mental health services for the client;

(3) developing an individual behavior plan that documents services to be provided by the mental health behavioral aide. The individual behavior plan must include:

(i) detailed instructions on the service to be provided;

(ii) time allocated to each service;

(iii) methods of documenting the child's behavior;

(iv) methods of monitoring the child's progress in reaching objectives; and

(v) goals to increase or decrease targeted behavior as identified in the individual treatment plan;

(4) clinical supervision of the mental health practitioner and mental health behavioral aide. A mental health professional must document the clinical supervision the professional provides by cosigning individual treatment plans and making entries in the client's record on supervisory activities. Clinical supervision does not include the authority to make or terminate court–ordered placements of the child. A clinical supervisor must be available for urgent consultation as required by the individual client's needs or the situation. Clinical supervision may occur individually or in a small group to discuss treatment and review progress toward goals. The focus of clinical supervision must be the client's treatment needs and progress and the mental health practitioner's or behavioral aide's ability to provide services;

(4a) CTSS certified provider entities providing day treatment programs must meet the conditions in items (i) to (iii):

(i) the supervisor must be present and available on the premises more than 50 percent of the time in a five–working–day period during which the supervisee is providing a mental health service;

(ii) the diagnosis and the client's individual treatment plan or a change in the diagnosis or individual treatment plan must be made by or reviewed, approved, and signed by the supervisor; and

(iii) every 30 days, the supervisor must review and sign the record of the client's care for all activities in the preceding 30–day period;

(4b) for all other services provided under CTSS, clinical supervision standards provided in items (i) to (iii) must be used:

(i) medical assistance shall reimburse a mental health practitioner who maintains a consulting relationship with a mental health professional who accepts full professional responsibility and is present on site for at least one observation during the first 12 hours in which the

mental health practitioner provides the individual, family, or group skills training to the child or the child's family;

(ii) thereafter, the mental health professional is required to be present on site for observation as clinically appropriate when the mental health practitioner is providing individual, family, or group skills training to the child or the child's family; and

(iii) the observation must be a minimum of one clinical unit. The on–site presence of the mental health professional must be documented in the child's record and signed by the mental health professional who accepts full professional responsibility;

(5) providing direction to a mental health behavioral aide. For entities that employ mental health behavioral aides, the clinical supervisor must be employed by the provider entity or other certified children's therapeutic supports and services provider entity to ensure necessary and appropriate oversight for the client's treatment and continuity of care. The mental health professional or mental health practitioner giving direction must begin with the goals on the individualized treatment plan, and instruct the mental health behavioral aide on how to construct therapeutic activities and interventions that will lead to goal attainment. The professional or practitioner giving direction must also instruct the mental health behavioral aide about the client's diagnosis, functional status, and other characteristics that are likely to affect service delivery. Direction must also include determining that the mental health behavioral aide has the skills to interact with the client and the client's family in ways that convey personal and cultural respect and that the aide actively solicits information relevant to treatment from the family. The aide must be able to clearly explain the activities the aide is doing with the client and the activities' relationship to treatment goals. Direction is more didactic than is supervision and requires the professional or practitioner providing it to continuously evaluate the mental health behavioral aide's ability to carry out the activities of the individualized treatment plan and the individualized behavior plan. When providing direction, the professional or practitioner must:

(i) review progress notes prepared by the mental health behavioral aide for accuracy and consistency with diagnostic assessment, treatment plan, and behavior goals and the professional or practitioner must approve and sign the progress notes;

(ii) identify changes in treatment strategies, revise the individual behavior plan, and communicate treatment instructions and methodologies as appropriate to ensure that treatment is implemented correctly;

(iii) demonstrate family–friendly behaviors that support healthy collaboration among the child, the child's family, and providers as treatment is planned and implemented;

(iv) ensure that the mental health behavioral aide is able to effectively communicate with the child, the child's family, and the provider; and

(v) record the results of any evaluation and corrective actions taken to modify the work of the mental health behavioral aide;

(6) providing service delivery that implements the individual treatment plan and meets the requirements under subdivision 9; and

(7) individual treatment plan review. The review must determine the extent to which the services have met the goals and objectives in the previous treatment plan. The review must assess the client's progress and ensure that services and treatment goals continue to be necessary and appropriate to the client and the client's family or foster family. Revision of the individual treatment plan does not require a new diagnostic assessment unless the client's mental health status has changed markedly. The updated treatment plan must be signed by the client, if appropriate, and by the client's parent or other person authorized by statute to give consent to the mental health services for the child.

[For text of subd 7, see M.S.2006]

Subd. 8. **Required preservice and continuing education.** (a) A provider entity shall establish a plan to provide preservice and continuing education for staff. The plan must clear-

ly describe the type of training necessary to maintain current skills and obtain new skills and that relates to the provider entity's goals and objectives for services offered.

(b) A provider that employs a mental health behavioral aide under this section must require the mental health behavioral aide to complete 30 hours of preservice training. The preservice training must include topics specified in Minnesota Rules, part 9535.4068, subparts 1 and 2, and parent team training. The preservice training must include 15 hours of in–person training of a mental health behavioral aide in mental health services delivery and eight hours of parent team training. Curricula for parent team training must be approved in advance by the commissioner. Components of parent team training include:

(1) partnering with parents;

(2) fundamentals of family support;

(3) fundamentals of policy and decision making;

(4) defining equal partnership;

(5) complexities of the parent and service provider partnership in multiple service delivery systems due to system strengths and weaknesses;

(6) sibling impacts;

(7) support networks; and

(8) community resources.

(c) A provider entity that employs a mental health practitioner and a mental health behavioral aide to provide children's therapeutic services and supports under this section must require the mental health practitioner and mental health behavioral aide to complete 20 hours of continuing education every two calendar years. The continuing education must be related to serving the needs of a child with emotional disturbance in the child's home environment and the child's family. The topics covered in orientation and training must conform to Minnesota Rules, part 9535.4068.

(d) The provider entity must document the mental health practitioner's or mental health behavioral aide's annual completion of the required continuing education. The documentation must include the date, subject, and number of hours of the continuing education, and attendance records, as verified by the staff member's signature, job title, and the instructor's name. The provider entity must keep documentation for each employee, including records of attendance at professional workshops and conferences, at a central location and in the employee's personnel file.

Subd. 9. **Service delivery criteria.** (a) In delivering services under this section, a certified provider entity must ensure that:

(1) each individual provider's caseload size permits the provider to deliver services to both clients with severe, complex needs and clients with less intensive needs. The provider's caseload size should reasonably enable the provider to play an active role in service planning, monitoring, and delivering services to meet the client's and client's family's needs, as specified in each client's individual treatment plan;

(2) site–based programs, including day treatment and preschool programs, provide staffing and facilities to ensure the client's health, safety, and protection of rights, and that the programs are able to implement each client's individual treatment plan;

(3) a day treatment program is provided to a group of clients by a multidisciplinary team under the clinical supervision of a mental health professional. The day treatment program must be provided in and by: (i) an outpatient hospital accredited by the Joint Commission on Accreditation of Health Organizations and licensed under sections 144.50 to 144.55; (ii) a community mental health center under section 245.62; and (iii) an entity that is under contract with the county board to operate a program that meets the requirements of sections 245.4712, subdivision 2, and 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475. The day treatment program must stabilize the client's mental health status while developing and improving the client's independent living and socialization skills. The goal of the day treatment program must be to reduce or relieve the effects of mental illness and provide training to enable the client to live in the community. The program

must be available at least one day a week for a three–hour time block. The three–hour time block must include at least one hour, but no more than two hours, of individual or group psychotherapy. The remainder of the three–hour time block may include recreation therapy, socialization therapy, or independent living skills therapy, but only if the therapies are included in the client's individual treatment plan. Day treatment programs are not part of inpatient or residential treatment services; and

(4) a preschool program is a structured treatment program offered to a child who is at least 33 months old, but who has not yet reached the first day of kindergarten, by a preschool multidisciplinary team in a day program licensed under Minnesota Rules, parts 9503.0005 to 9503.0175. The program must be available at least one day a week for a minimum two–hour time block. The structured treatment program may include individual or group psychotherapy and recreation therapy, socialization therapy, or independent living skills therapy, if included in the client's individual treatment plan.

(b) A provider entity must deliver the service components of children's therapeutic services and supports in compliance with the following requirements:

(1) individual, family, and group psychotherapy must be delivered as specified in Minnesota Rules, part 9505.0323;

(2) individual, family, or group skills training must be provided by a mental health professional or a mental health practitioner who has a consulting relationship with a mental health professional who accepts full professional responsibility for the training;

(3) crisis assistance must be time–limited and designed to resolve or stabilize crisis through arrangements for direct intervention and support services to the child and the child's family. Crisis assistance must utilize resources designed to address abrupt or substantial changes in the functioning of the child or the child's family as evidenced by a sudden change in behavior with negative consequences for well being, a loss of usual coping mechanisms, or the presentation of danger to self or others;

(4) medically necessary services that are provided by a mental health behavioral aide must be designed to improve the functioning of the child and support the family in activities of daily and community living. A mental health behavioral aide must document the delivery of services in written progress notes. The mental health behavioral aide must implement goals in the treatment plan for the child's emotional disturbance that allow the child to acquire developmentally and therapeutically appropriate daily living skills, social skills, and leisure and recreational skills through targeted activities. These activities may include:

(i) assisting a child as needed with skills development in dressing, eating, and toileting;

(ii) assisting, monitoring, and guiding the child to complete tasks, including facilitating the child's participation in medical appointments;

(iii) observing the child and intervening to redirect the child's inappropriate behavior;

(iv) assisting the child in using age–appropriate self–management skills as related to the child's emotional disorder or mental illness, including problem solving, decision making, communication, conflict resolution, anger management, social skills, and recreational skills;

(v) implementing deescalation techniques as recommended by the mental health professional;

(vi) implementing any other mental health service that the mental health professional has approved as being within the scope of the behavioral aide's duties; or

(vii) assisting the parents to develop and use parenting skills that help the child achieve the goals outlined in the child's individual treatment plan or individual behavioral plan. Parenting skills must be directed exclusively to the child's treatment; and

(5) direction of a mental health behavioral aide must include the following:

(i) a total of one hour of on–site observation by a mental health professional during the first 12 hours of service provided to a child;

(ii) ongoing on–site observation by a mental health professional or mental health practitioner for at least a total of one hour during every 40 hours of service provided to a child; and

(iii) immediate accessibility of the mental health professional or mental health practitioner to the mental health behavioral aide during service provision.

[For text of subd 10, see M.S.2006]

Subd. 11. **Documentation and billing.** (a) A provider entity must document the services it provides under this section. The provider entity must ensure that the entity's documentation standards meet the requirements of federal and state laws. Services billed under this section that are not documented according to this subdivision shall be subject to monetary recovery by the commissioner. The provider entity may not bill for anything other than direct service time.

(b) An individual mental health provider must promptly document the following in a client's record after providing services to the client:

(1) each occurrence of the client's mental health service, including the date, type, length, and scope of the service;

(2) the name of the person who gave the service;

(3) contact made with other persons interested in the client, including representatives of the courts, corrections systems, or schools. The provider must document the name and date of each contact;

(4) any contact made with the client's other mental health providers, case manager, family members, primary caregiver, legal representative, or the reason the provider did not contact the client's family members, primary caregiver, or legal representative, if applicable; and

(5) required clinical supervision, as appropriate.

Subd. 12. **Excluded services.** The following services are not eligible for medical assistance payment as children's therapeutic services and supports:

(1) service components of children's therapeutic services and supports simultaneously provided by more than one provider entity unless prior authorization is obtained;

(2) children's therapeutic services and supports provided in violation of medical assistance policy in Minnesota Rules, part 9505.0220;

(3) mental health behavioral aide services provided by a personal care assistant who is not qualified as a mental health behavioral aide and employed by a certified children's therapeutic services and supports provider entity;

(4) service components of CTSS that are the responsibility of a residential or program license holder, including foster care providers under the terms of a service agreement or administrative rules governing licensure;

(5) adjunctive activities that may be offered by a provider entity but are not otherwise covered by medical assistance, including:

(i) a service that is primarily recreation oriented or that is provided in a setting that is not medically supervised. This includes sports activities, exercise groups, activities such as craft hours, leisure time, social hours, meal or snack time, trips to community activities, and tours;

(ii) a social or educational service that does not have or cannot reasonably be expected to have a therapeutic outcome related to the client's emotional disturbance;

(iii) consultation with other providers or service agency staff about the care or progress of a client;

(iv) prevention or education programs provided to the community; and

(v) treatment for clients with primary diagnoses of alcohol or other drug abuse; and

(6) activities that are not direct service time.

[For text of subd 13, see M.S.2006]

History: *2007 c 147 art 8 s 22; art 11 s 18–21*

256B.0944 CHILDREN'S MENTAL HEALTH CRISIS RESPONSE SERVICES.

[For text of subds 1 to 3, see M.S.2006]

Subd. 4. **Provider entity standards.** (a) A crisis intervention and crisis stabilization provider entity must meet the administrative and clinical standards specified in section 256B.0943, subdivisions 5 and 6, meet the standards listed in paragraph (b), and be:

(1) an Indian health service facility or facility owned and operated by a tribe or a tribal organization operating under Public Law 93–638 as a 638 facility;

(2) a county board–operated entity; or

(3) a provider entity that is under contract with the county board in the county where the potential crisis or emergency is occurring.

(b) The children's mental health crisis response services provider entity must:

(1) ensure that mental health crisis assessment and mobile crisis intervention services are available 24 hours a day, seven days a week;

(2) directly provide the services or, if services are subcontracted, the provider entity must maintain clinical responsibility for services and billing;

(3) ensure that crisis intervention services are provided in a manner consistent with sections 245.487 to 245.4889; and

(4) develop and maintain written policies and procedures regarding service provision that include safety of staff and recipients in high–risk situations.

[For text of subds 5 to 11, see M.S.2006]

History: *2007 c 147 art 8 s 38*

256B.0945 SERVICES FOR CHILDREN WITH SEVERE EMOTIONAL DISTURBANCE.

[For text of subds 1 to 3, see M.S.2006]

Subd. 4. **Payment rates.** (a) Notwithstanding sections 256B.19 and 256B.041, payments to counties for residential services provided by a residential facility shall only be made of federal earnings for services provided under this section, and the nonfederal share of costs for services provided under this section shall be paid by the county from sources other than federal funds or funds used to match other federal funds. Payment to counties for services provided according to this section shall be a proportion of the per day contract rate that relates to rehabilitative mental health services and shall not include payment for costs or services that are billed to the IV–E program as room and board.

(b) Per diem rates paid to providers under this section by prepaid plans shall be the proportion of the per–day contract rate that relates to rehabilitative mental health services and shall not include payment for group foster care costs or services that are billed to the county of financial responsibility.

(c) The commissioner shall set aside a portion not to exceed five percent of the federal funds earned for county expenditures under this section to cover the state costs of administering this section. Any unexpended funds from the set–aside shall be distributed to the counties in proportion to their earnings under this section.

History: *2007 c 147 art 8 s 23*

NOTE: The amendment to subdivision 4 by Laws 2007, chapter 147, article 8, section 23, is effective January 1, 2009. Laws 2007, chapter 147, article 8, section 23, the effective date.

256B.0946 TREATMENT FOSTER CARE.

Subdivision 1. **Covered service.** (a) Effective July 1, 2006, and subject to federal approval, medical assistance covers medically necessary services described under paragraph (b) that are provided by a provider entity eligible under subdivision 3 to a client eligible under subdivision 2 who is placed in a treatment foster home licensed under Minnesota Rules, parts 2960.3000 to 2960.3340.

(b) Services to children with severe emotional disturbance residing in treatment foster care settings must meet the relevant standards for mental health services under sections

245.487 to 245.4889. In addition, specific service components reimbursed by medical assistance must meet the following standards:

(1) case management service component must meet the standards in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10;

(2) psychotherapy, crisis assistance, and skills training components must meet the standards for children's therapeutic services and supports in section 256B.0943; and

(3) family psychoeducation services under supervision of a mental health professional.

[For text of subds 2 to 6, see M.S.2006]

History: *2007 c 147 art 8 s 38*

256B.095 QUALITY ASSURANCE SYSTEM ESTABLISHED.

(a) Effective July 1, 1998, a quality assurance system for persons with developmental disabilities, which includes an alternative quality assurance licensing system for programs, is established in Dodge, Fillmore, Freeborn, Goodhue, Houston, Mower, Olmsted, Rice, Steele, Wabasha, and Winona Counties for the purpose of improving the quality of services provided to persons with developmental disabilities. A county, at its option, may choose to have all programs for persons with developmental disabilities located within the county licensed under chapter 245A using standards determined under the alternative quality assurance licensing system or may continue regulation of these programs under the licensing system operated by the commissioner. The project expires on June 30, 2014.

(b) Effective July 1, 2003, a county not listed in paragraph (a) may apply to participate in the quality assurance system established under paragraph (a). The commission established under section 256B.0951 may, at its option, allow additional counties to participate in the system.

(c) Effective July 1, 2003, any county or group of counties not listed in paragraph (a) may establish a quality assurance system under this section. A new system established under this section shall have the same rights and duties as the system established under paragraph (a). A new system shall be governed by a commission under section 256B.0951. The commissioner shall appoint the initial commission members based on recommendations from advocates, families, service providers, and counties in the geographic area included in the new system. Counties that choose to participate in a new system shall have the duties assigned under section 256B.0952. The new system shall establish a quality assurance process under section 256B.0953. The provisions of section 256B.0954 shall apply to a new system established under this paragraph. The commissioner shall delegate authority to a new system established under this paragraph according to section 256B.0955.

(d) Effective July 1, 2007, the quality assurance system may be expanded to include programs for persons with disabilities and older adults.

History: *2007 c 147 art 7 s 16*

256B.0951 QUALITY ASSURANCE COMMISSION.

Subdivision 1. **Membership.** The Quality Assurance Commission is established. The commission consists of at least 14 but not more than 21 members as follows: at least three but not more than five members representing advocacy organizations; at least three but not more than five members representing consumers, families, and their legal representatives; at least three but not more than five members representing service providers; at least three but not more than five members representing counties; and the commissioner of human services or the commissioner's designee. The first commission shall establish membership guidelines for the transition and recruitment of membership for the commission's ongoing existence. Members of the commission who do not receive a salary or wages from an employer for time spent on commission duties may receive a per diem payment when performing commission duties and functions. All members may be reimbursed for expenses related to commission activities. Notwithstanding the provisions of section 15.059, subdivision 5, the commission expires on June 30, 2014.

[For text of subds 2 to 9, see M.S.2006]

History: *2007 c 147 art 7 s 17*

256B.096 QUALITY MANAGEMENT, ASSURANCE, AND IMPROVEMENT SYSTEM FOR MINNESOTANS RECEIVING DISABILITY SERVICES.

Subdivision 1. **Scope.** In order to improve the quality of services provided to Minnesotans with disabilities and to meet the requirements of the federally approved home and community–based waivers under section 1915c of the Social Security Act, a statewide quality assurance and improvement system for Minnesotans receiving disability services shall be developed. The disability services included are the home and community–based services waiver programs for persons with developmental disabilities under section 256B.092, subdivision 4, and for persons with disabilities under section 256B.49.

Subd. 2. **Stakeholder advisory group.** The commissioner shall consult with a stakeholder advisory group on the development and implementation of the state quality management, assurance, and improvement system, including representatives of disability service recipients, disability service providers, disability advocacy groups, county human service agencies, and state agency staff from the Departments of Human Services and Health, and the ombudsman for mental health and developmental disabilities on the development of a statewide quality assurance and improvement system.

Subd. 3. **Annual survey of service recipients.** The commissioner, in consultation with the stakeholder advisory group, shall develop an annual independent random statewide survey of between five and ten percent of service recipients to determine the effectiveness and quality of disability services. The survey shall be consistent with the system performance expectations of the Centers for Medicare and Medicaid Services quality management requirements and framework. The survey shall analyze whether desired outcomes have been achieved for persons with different demographic, diagnostic, health, and functional needs receiving different types of services, in different settings, with different costs. The survey shall be field tested during 2008. The biennial report established in subdivision 5 shall include recommendations on statewide and regional reports of the survey results that, if published, would be useful to regions, counties, and providers to plan and measure the impact of quality improvement activities.

Subd. 4. **Improvements for incident reporting, investigation, analysis, and follow–up.** In consultation with the stakeholder advisory group, the commissioner shall identify the information, data sources, and technology needed to improve the system of incident reporting, including:

(1) reports made under the Maltreatment of Minors and Vulnerable Adults Acts; and

(2) investigation, analysis, and follow–up for disability services.

The commissioner must ensure that the federal home and community–based waiver requirements are met and that incidents that may have jeopardized safety and health or violated service–related assurances, civil and human rights, and other protections designed to prevent abuse, neglect, and exploitation, are reviewed, investigated, and acted upon in a timely manner.

Subd. 5. **Biennial report.** The commissioner shall provide a biennial report to the chairs of the legislative committees with jurisdiction over health and human services policy and funding beginning January 15, 2009, on the development and activities of the quality management, assurance, and improvement system designed to meet the federal requirements under the home and community–based services waiver programs for persons with disabilities. By January 15, 2008, the commissioner shall provide a preliminary report on priorities for meeting the federal requirements, progress on development and field testing of the annual survey, appropriations necessary to implement an annual survey of service recipients once field testing is completed, recommendations for improvements in the incident reporting sys-

tem, and a plan for incorporating quality assurance efforts under section 256B.095 and other regional efforts into the statewide system.

History: *2007 c 147 art 7 s 18*

256B.199 PAYMENTS REPORTED BY GOVERNMENTAL ENTITIES.

(a) Effective July 1, 2007, the commissioner shall apply for federal matching funds for the expenditures in paragraphs (b) and (c).

(b) The commissioner shall apply for federal matching funds for certified public expenditures as follows:

(1) Hennepin County, Hennepin County Medical Center, Ramsey County, Regions Hospital, the University of Minnesota, and Fairview–University Medical Center shall report quarterly to the commissioner beginning June 1, 2007, payments made during the second previous quarter that may qualify for reimbursement under federal law;

(2) based on these reports, the commissioner shall apply for federal matching funds. These funds are appropriated to the commissioner for the payments under section 256.969, subdivision 27; and

(3) by May 1 of each year, beginning May 1, 2007, the commissioner shall inform the nonstate entities listed in paragraph (a) of the amount of federal disproportionate share hospital payment money expected to be available in the current federal fiscal year.

(c) The commissioner shall apply for federal matching funds for general assistance medical care expenditures as follows:

(1) for hospital services occurring on or after July 1, 2007, general assistance medical care expenditures for fee–for–service inpatient and outpatient hospital payments made by the department shall be used to apply for federal matching funds, except as limited below:

(i) only those general assistance medical care expenditures made to an individual hospital that would not cause the hospital to exceed its individual hospital limits under section 1923 of the Social Security Act may be considered; and

(ii) general assistance medical care expenditures may be considered only to the extent of Minnesota's aggregate allotment under section 1923 of the Social Security Act; and

(2) all hospitals must provide any necessary expenditure, cost, and revenue information required by the commissioner as necessary for purposes of obtaining federal Medicaid matching funds for general assistance medical care expenditures.

History: *2007 c 147 art 5 s 13*

256B.27 MEDICAL ASSISTANCE; COST REPORTS.

[For text of subds 1 and 2, see M.S.2006]

Subd. 2a. **Cost and statistical data audits.** The commissioner shall provide for an audit of the cost and statistical data of nursing facilities participating as vendors of medical assistance. The commissioner shall select for audit at least 15 percent of the nursing facilities' data reported at random or using factors including, but not limited to: data reported to the public as criteria for rating nursing facilities; data used to set limits for other medical assistance programs or vendors of services to nursing facilities; change in ownership; frequent changes in administration in excess of normal turnover rates; complaints to the commissioner of health about care, safety, or rights; where previous inspections or reinspections under section 144A.10 have resulted in correction orders related to care, safety, or rights; or where persons involved in ownership or administration of the facility have been indicted for alleged criminal activity.

The commissioner shall meet the 15 percent requirement by either conducting an audit focused on an individual nursing facility, a group of facilities, or targeting specific data categories in multiple nursing facilities. These audits may be conducted on site at the nursing facility, at office space used by a nursing facility or a nursing facility's parent organization, or

at the commissioner's office. Data being audited may be collected electronically, in person, or by any other means the commissioner finds acceptable.

[For text of subds 3 to 5, see M.S.2006]

History: *2007 c 147 art 6 s 40*

256B.431 RATE DETERMINATION.

Subdivision 1. **In general.** The commissioner shall determine prospective payment rates for resident care costs. For rates established on or after July 1, 1985, the commissioner shall develop procedures for determining operating cost payment rates that take into account the mix of resident needs, geographic location, and other factors as determined by the commissioner. The commissioner shall consider whether the fact that a facility is attached to a hospital or has an average length of stay of 180 days or less should be taken into account in determining rates. The commissioner shall consider the use of the standard metropolitan statistical areas when developing groups by geographic location. The commissioner shall provide notice to each nursing facility on or before August 15 of the rates effective for the following rate year except that if legislation is pending on August 15 that may affect rates for nursing facilities, the commissioner shall set the rates after the legislation is enacted and provide notice to each facility as soon as possible.

Compensation for top management personnel shall continue to be categorized as a general and administrative cost and is subject to any limits imposed on that cost category.

[For text of subds 2b to 2d, see M.S.2006]

Subd. 2e. **Contracts for services for ventilator–dependent persons.** (a) The commissioner may negotiate 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 hospitalized and no longer requires inpatient acute care hospital services; and

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

The commissioner may negotiate an adjustment to the operating cost payment rate for a nursing facility with a resident who is ventilator–dependent, for that resident. 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. For persons who are initially admitted to a nursing facility before July 1, 2001, and have their payment rate under this subdivision negotiated after July 1, 2001, the negotiated payment rate must not exceed 200 percent of the highest multiple bedroom payment rate for the facility, as initially established by the commissioner for the rate year for case mix classification K; or, upon implementation of the RUG's–based case mix system, 200 percent of the highest RUG's rate. For persons initially admitted to a nursing facility on or after July 1, 2001, the negotiated payment rate must not exceed 300 percent of the facility's multiple bedroom payment rate for case mix classification K; or, upon implementation of the RUG's–based case mix system, 300 percent of the highest RUG's rate. The negotiated adjustment shall not affect the payment rate charged to private paying residents under the provisions of section 256B.48, subdivision 1.

(b) Effective July 1, 2007, or upon opening a unit of at least ten beds dedicated to care of ventilator–dependent persons in partnership with Mayo Health Systems, whichever is later, the operating payment rates for residents determined eligible under paragraph (a) of a nurs-

ing facility in Waseca County that on February 1, 2007, was licensed for 70 beds and reimbursed under this section, section 256B.434, or section 256B.441, shall be 300 percent of the facility's highest RUG rate.

[For text of subds 2g to 3e, see M.S.2006]

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 Economic Analysis: Price Indexes for Private Fixed Investments in Structures; Special Care.

(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 arm's–length transactions at the time the debt was incurred. If the debt was incurred due to a sale between family members, the nursing facility must also demonstrate that the seller no longer participates in the management or operation of the nursing facility. Debts meeting the conditions of this paragraph are subject to all other provisions of Minnesota Rules, parts 9549.0010 to 9549.0080.

(f) **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. If an operating lease provides that the lessee's rent is adjusted to recognize improvements made by the lessor and related debt, the costs for capital improvements and related debt shall be allowed in the computation of the lessee's building capital allowance, provided that reimbursement for these costs under an operating lease shall not exceed the rate otherwise paid.

[For text of subds 3g to 17, see M.S.2006]

Subd. 17a. **Allowable interest expense.** (a) Notwithstanding Minnesota Rules, part 9549.0060, subparts 5, item A, subitems (1) and (3), and 7, item D, allowable interest expense on debt shall include:

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

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

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

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

[For text of subds 17b to 17d, see M.S.2006]

Subd. 17e. **Replacement–costs–new per bed limit effective October 1, 2007.** Notwithstanding Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), for a total replacement, as defined in subdivision 17d, authorized under section 144A.071 or 144A.073 after July 1, 1999, any building project that is a relocation, renovation, upgrading, or conversion completed on or after July 1, 2001, or any building project eligible for reimbursement under section 256B.434, subdivision 4f, the replacement–costs–new per bed limit shall be $74,280 per licensed bed in multiple–bed rooms, $92,850 per licensed bed in semiprivate rooms with a fixed partition separating the resident beds, and $111,420 per licensed bed in single rooms. Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), does not apply. These amounts must be adjusted annually as specified in subdivision 3f, paragraph (a), beginning January 1, 2000.

[For text of subds 17f to 40, see M.S.2006]

Subd. 41. **Rate increases for October 1, 2005, and October 1, 2006.** (a) For the rate period beginning October 1, 2005, the commissioner shall make available to each nursing facility reimbursed under this section or section 256B.434 an adjustment equal to 2.2553 percent of the total operating payment rate, and for the rate year beginning October 1, 2006, the commissioner shall make available to each nursing facility reimbursed under this section or section 256B.434 an adjustment equal to 1.2553 percent of the total operating payment rate.

(b) 75 percent of the money resulting from the rate adjustment under paragraph (a) must be used to increase wages and benefits and pay associated costs for all employees, except management fees, the administrator, and central office staff. Except as provided in paragraph (c), 75 percent of the money received by a facility as a result of the rate adjustment provided in paragraph (a) must be used only for wage, benefit, and staff increases implemented on or after the effective date of the rate increase each year, and must not be used for increases implemented prior to that date.

(c) With respect only to the October 1, 2005, rate increase, a nursing facility that incurred costs for salary and employee benefit increases first provided after July 1, 2003, may

count those costs towards the amount required to be spent on salaries and benefits under paragraph (b). These costs must be reported to the commissioner in the form and manner specified by the commissioner.

(d) Nursing facilities may apply for the portion of the rate adjustment under paragraph (a) for employee wages and benefits and associated costs. The application must be made to the commissioner and contain a plan by which the nursing facility will distribute the funds according to paragraph (b). For nursing facilities in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes the plan. A negotiated agreement may constitute the plan only if the agreement is finalized after the date of enactment of all increases for the rate year and signed by both parties prior to submission to the commissioner. The commissioner shall review the plan to ensure that the rate adjustments are used as provided in paragraph (b). To be eligible, a facility must submit its distribution plan by March 31, 2006, and March 31, 2007, respectively. The commissioner may approve distribution plans on or before June 30, 2006, and June 30, 2007, respectively. The commissioner may waive the deadlines in this paragraph under extraordinary circumstances, either retroactively or prospectively, to be determined at the sole discretion of the commissioner. If a facility's distribution plan is effective after the first day of the applicable rate period that the funds are available, the rate adjustments are effective the same date as the facility's plan.

(e) A copy of the approved distribution plan must be made available to all employees by giving each employee a copy or by posting a copy in an area of the nursing facility to which all employees have access. If an employee does not receive the wage and benefit adjustment described in the facility's approved plan and is unable to resolve the problem with the facility's management or through the employee's union representative, the employee may contact the commissioner at an address or telephone number provided by the commissioner and included in the approved plan.

[For text of subds 42 and 43, see M.S.2006]

History: *2007 c 147 art 6 s 41–44; art 7 s 19,20*

256B.434 ALTERNATIVE PAYMENT DEMONSTRATION PROJECT.

[For text of subds 1 to 3, see M.S.2006]

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, 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.

(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 and, for facilities reimbursed under this section or section 256B.431, an adjustment to include the cost of any increase in Health Department licensing fees for the facility taking effect on or after July 1, 2001. 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 the commissioner of finance's national economic consultant, 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. For the rate years beginning on July 1, 1999, July 1, 2000, July 1, 2001, July 1, 2002, July 1, 2003, July 1, 2004, July 1, 2005, July 1, 2006, July 1, 2007, July 1, 2008, October 1, 2009, and October 1, 2010, this paragraph shall apply only to the property–related payment rate, except that adjustments to include the cost of any increase in Health Department licensing fees taking effect on or after

July 1, 2001, shall be provided. Beginning in 2005, adjustment to the property payment rate under this section and section 256B.431 shall be effective on October 1. In determining the amount of the property–related payment rate adjustment under this paragraph, the commissioner shall determine the proportion of the facility's rates that are property–related based on the facility's most recent cost report.

(d) The commissioner shall develop additional incentive–based payments of up to five percent above a facility's operating payment rate for achieving outcomes specified in a contract. The commissioner may solicit contract amendments and implement those which, on a competitive basis, best meet the state's policy objectives. The commissioner shall limit the amount of any incentive payment and the number of contract amendments under this paragraph to operate the incentive payments within funds appropriated for this purpose. The contract amendments may specify various levels of payment for various levels of performance. Incentive payments to facilities under this paragraph may be in the form of time–limited rate adjustments or onetime supplemental payments. In establishing the specified outcomes and related criteria, the commissioner shall consider the following state policy objectives:

(1) successful diversion or discharge of residents to the residents' prior home or other community–based alternatives;

(2) adoption of new technology to improve quality or efficiency;

(3) improved quality as measured in the Nursing Home Report Card;

(4) reduced acute care costs; and

(5) any additional outcomes proposed by a nursing facility that the commissioner finds desirable.

(e) Notwithstanding the threshold in section 256B.431, subdivision 16, facilities that take action to come into compliance with existing or pending requirements of the life safety code provisions or federal regulations governing sprinkler systems must receive reimbursement for the costs associated with compliance if all of the following conditions are met:

(1) the expenses associated with compliance occurred on or after January 1, 2005, and before December 31, 2008;

(2) the costs were not otherwise reimbursed under subdivision 4f or section 144A.071 or 144A.073; and

(3) the total allowable costs reported under this paragraph are less than the minimum threshold established under section 256B.431, subdivision 15, paragraph (e), and subdivision 16.

The commissioner shall use money appropriated for this purpose to provide to qualifying nursing facilities a rate adjustment beginning October 1, 2007, and ending September 30, 2008. Nursing facilities that have spent money or anticipate the need to spend money to satisfy the most recent life safety code requirements by (1) installing a sprinkler system or (2) replacing all or portions of an existing sprinkler system may submit to the commissioner by June 30, 2007, on a form provided by the commissioner the actual costs of a completed project or the estimated costs, based on a project bid, of a planned project. The commissioner shall calculate a rate adjustment equal to the allowable costs of the project divided by the resident days reported for the report year ending September 30, 2006. If the costs from all projects exceed the appropriation for this purpose, the commissioner shall allocate the money appropriated on a pro rata basis to the qualifying facilities by reducing the rate adjustment determined for each facility by an equal percentage. Facilities that used estimated costs when requesting the rate adjustment shall report to the commissioner by January 31, 2009, on the use of this money on a form provided by the commissioner. If the nursing facility fails to provide the report, the commissioner shall recoup the money paid to the facility for this purpose. If the facility reports expenditures allowable under this subdivision that are less than the amount received in the facility's annualized rate adjustment, the commissioner shall recoup the difference.

[For text of subds 4a to 18, see M.S.2006]

Subd. 19. **Nursing facility rate increases beginning October 1, 2007.** (a) For the rate year beginning October 1, 2007, the commissioner shall make available to each nursing facility reimbursed under this section operating payment rate adjustments equal to 1.87 percent of the operating payment rates in effect on September 30, 2007.

(b) Seventy–five percent of the money resulting from the rate adjustment under paragraph (a) must be used for increases in compensation–related costs for employees directly employed by the nursing facility on or after the effective date of the rate adjustment, except:

(1) the administrator;

(2) persons employed in the central office of a corporation that has an ownership interest in the nursing facility or exercises control over the nursing facility; and

(3) persons paid by the nursing facility under a management contract.

(c) Two–thirds of the money available under paragraph (b) must be used for wage increases for all employees directly employed by the nursing facility on or after the effective date of the rate adjustment, except those listed in paragraph (b), clauses (1) to (3). The wage adjustment that employees receive under this paragraph must be paid as an equal hourly percentage wage increase for all eligible employees. All wage increases under this paragraph must be effective on the same date. Only costs associated with the portion of the equal hourly percentage wage increase that goes to all employees shall qualify under this paragraph. Costs associated with wage increases in excess of the amount of the equal hourly percentage wage increase provided to all employees shall be allowed only for meeting the requirements in paragraph (b). This paragraph shall not apply to employees covered by a collective bargaining agreement.

(d) The commissioner shall allow as compensation–related costs all costs for:

(1) wages and salaries;

(2) FICA taxes, Medicare taxes, state and federal unemployment taxes, and workers' compensation;

(3) the employer's share of health and dental insurance, life insurance, disability insurance, long–term care insurance, uniform allowance, and pensions; and

(4) other benefits provided, subject to the approval of the commissioner.

(e) The portion of the rate adjustment under paragraph (a) that is not subject to the requirements in paragraphs (b) and (c) shall be provided to nursing facilities effective October 1, 2007.

(f) Nursing facilities may apply for the portion of the rate adjustment under paragraph (a) that is subject to the requirements in paragraphs (b) and (c). The application must be submitted to the commissioner within six months of the effective date of the rate adjustment, and the nursing facility must provide additional information required by the commissioner within nine months of the effective date of the rate adjustment. The commissioner must respond to all applications within three weeks of receipt. The commissioner may waive the deadlines in this paragraph under extraordinary circumstances, to be determined at the sole discretion of the commissioner. The application must contain:

(1) an estimate of the amounts of money that must be used as specified in paragraphs (b) and (c);

(2) a detailed distribution plan specifying the allowable compensation–related and wage increases the nursing facility will implement to use the funds available in clause (1);

(3) a description of how the nursing facility will notify eligible employees of the contents of the approved application, which must provide for giving each eligible employee a copy of the approved application, excluding the information required in clause (1), or posting a copy of the approved application, excluding the information required in clause (1), for a period of at least six weeks in an area of the nursing facility to which all eligible employees have access; and

(4) instructions for employees who believe they have not received the compensation–related or wage increases specified in clause (2), as approved by the commissioner, and

which must include a mailing address, e–mail address, and the telephone number that may be used by the employee to contact the commissioner or the commissioner's representative.

(g) The commissioner shall ensure that cost increases in distribution plans under paragraph (f), clause (2), that may be included in approved applications, comply with the following requirements:

(1) costs to be incurred during the applicable rate year resulting from wage and salary increases effective after October 1, 2006, and prior to the first day of the nursing facility's payroll period that includes October 1, 2007, shall be allowed if they were not used in the prior year's application;

(2) a portion of the costs resulting from tenure–related wage or salary increases may be considered to be allowable wage increases, according to formulas that the commissioner shall provide, where employee retention is above the average statewide rate of retention of direct care employees;

(3) the annualized amount of increases in costs for the employer's share of health and dental insurance, life insurance, disability insurance, and workers' compensation shall be allowable compensation–related increases if they are effective on or after April 1, 2007, and prior to April 1, 2008; and

(4) for nursing facilities in which employees are represented by an exclusive bargaining representative, the commissioner shall approve the application only upon receipt of a letter of acceptance of the distribution plan, in regard to members of the bargaining unit, signed by the exclusive bargaining agent and dated after May 25, 2007. Upon receipt of the letter of acceptance, the commissioner shall deem all requirements of this section as having been met in regard to the members of the bargaining unit.

(h) The commissioner shall review applications received under paragraph (f) and shall provide the portion of the rate adjustment under paragraphs (b) and (c) if the requirements of this subdivision have been met. The rate adjustment shall be effective October 1. Notwithstanding paragraph (a), if the approved application distributes less money than is available, the amount of the rate adjustment shall be reduced so that the amount of money made available is equal to the amount to be distributed.

Subd. 20. **Payment of Public Employees Retirement Association costs.** Nursing facilities that participate in the Public Employees Retirement Association (PERA) shall have the component of their payment rate associated with the costs of PERA determined for each rate year. Effective for rate years beginning on and after October 1, 2007, the commissioner shall determine the portion of the payment rate in effect on September 30 each year and shall subtract that amount from the payment rate to be effective on the following October 1. The portion that shall be deemed to be included in the September 30, 2007, rate that is associated with PERA costs shall be the allowed costs in the facility's base for determining rates under this section, divided by the resident days reported for that year. The commissioner shall add to the payment rate to be effective on October 1 each year an amount equal to the reported costs associated with PERA, for the year ending on the most recent September 30 for which data is available, divided by total resident days for that year, as reported by the facility and audited under section 256B.441.

History: *2007 c 147 art 7 s 21–23*

256B.437 NURSING FACILITY VOLUNTARY CLOSURE; ALTERNATIVES.

[For text of subds 1 to 9, see M.S.2006]

Subd. 10. **Big Stone County rate adjustment.** Notwithstanding the requirements of this section, the commissioner shall approve a planned closure rate adjustment in Big Stone County for an eight–bed facility in Clinton for reassignment to a 50–bed facility in Graceville. The adjustment shall be calculated according to subdivisions 3 and 6.

History: *2007 c 147 art 7 s 24*

256B.441 VALUE-BASED NURSING FACILITY REIMBURSEMENT SYSTEM.

Subdivision 1. **Rebasing of nursing facility operating cost payment rates.** (a) The commissioner shall rebase nursing facility operating cost payment rates to align payments to facilities with the cost of providing care. The rebased operating cost payment rates shall be calculated using the statistical and cost report filed by each nursing facility for the report period ending one year prior to the rate year.

(b) The new operating cost payment rates based on this section shall take effect beginning with the rate year beginning October 1, 2008, and shall be phased in over eight rate years through October 1, 2015.

(c) Operating cost payment rates shall be rebased on October 1, 2016, and every two years after that date.

(d) Each cost reporting year shall begin on October 1 and end on the following September 30. Beginning in 2006, a statistical and cost report shall be filed by each nursing facility by January 15. Notice of rates shall be distributed by August 15 and the rates shall go into effect on October 1 for one year.

(e) Effective October 1, 2014, property rates shall be rebased in accordance with section 256B.431 and Minnesota Rules, chapter 9549. The commissioner shall determine what the property payment rate for a nursing facility would be had the facility not had its property rate determined under section 256B.434. The commissioner shall allow nursing facilities to provide information affecting this rate determination that would have been filed annually under Minnesota Rules, chapter 9549, and nursing facilities shall report information necessary to determine allowable debt. The commissioner shall use this information to determine the property payment rate.

Subd. 2. **Definitions.** For purposes of this section, the terms in subdivisions 3 to 42a have the meanings given unless otherwise provided for in this section.

[For text of subds 3 and 4, see M.S.2006]

Subd. 5. **Administrative costs.** "Administrative costs" means the direct costs for administering the overall activities of the nursing home. These costs include salaries and wages of the administrator, assistant administrator, business office employees, security guards, and associated fringe benefits and payroll taxes, fees, contracts, or purchases related to business office functions, licenses, and permits except as provided in the external fixed costs category, employee recognition, travel including meals and lodging, training, voice and data communication or transmission, office supplies, liability insurance and other forms of insurance not designated to other areas, personnel recruitment, legal services, accounting services, management or business consultants, data processing, information technology, Web site, central or home office costs, business meetings and seminars, postage, fees for professional organizations, subscriptions, security services, advertising, board of director's fees, working capital interest expense, and bad debts and bad debt collection fees.

Subd. 6. **Allowed costs.** "Allowed costs" means the amounts reported by the facility which are necessary for the operation of the facility and the care of residents and which are reviewed by the department for accuracy; reasonableness, in accordance with the requirements set forth in Title XVIII of the federal Social Security Act and the interpretations in the provider reimbursement manual; and compliance with this section and generally accepted accounting principles. All references to costs in this section shall be assumed to refer to allowed costs.

[For text of subds 7 to 9, see M.S.2006]

Subd. 10. **Dietary costs.** "Dietary costs" means the costs for the salaries and wages of the dietary supervisor, dietitians, chefs, cooks, dishwashers, and other employees assigned to the kitchen and dining room, and associated fringe benefits and payroll taxes. Dietary costs also includes the salaries or fees of dietary consultants, dietary supplies, and food preparation and serving.

Subd. 11. **Direct care costs.** "Direct care costs" means costs for the wages of nursing administration, staff education, direct care registered nurses, licensed practical nurses, certified nursing assistants, trained medication aides, and associated fringe benefits and payroll taxes; services from a supplemental nursing services agency; supplies that are stocked at nursing stations or on the floor and distributed or used individually, including, but not limited to: alcohol, applicators, cotton balls, incontinence pads, disposable ice bags, dressings, bandages, water pitchers, tongue depressors, disposable gloves, enemas, enema equipment, soap, medication cups, diapers, plastic waste bags, sanitary products, thermometers, hypodermic needles and syringes, clinical reagents or similar diagnostic agents, drugs that are not paid on a separate fee schedule by the medical assistance program or any other payer, and technology related to the provision of nursing care to residents, such as electronic charting systems.

Subd. 12. [Repealed, 2007 c 147 art 7 s 76]

Subd. 13. **External fixed costs.** "External fixed costs" means costs related to the nursing home surcharge under section 256.9657, subdivision 1; licensure fees under section 144.122; long–term care consultation fees under section 256B.0911, subdivision 6; family advisory council fee under section 144A.33; scholarships under section 256B.431, subdivision 36; planned closure rate adjustments under section 256B.436 or 256B.437; or single bed room incentives under section 256B.431, subdivision 42; property taxes and property insurance; and PERA.

Subd. 14. **Facility average case mix index.** "Facility average case mix index" or "CMI" means a numerical value score that describes the relative resource use for all residents within the groups under the resource utilization group (RUG–III) classification system prescribed by the commissioner based on an assessment of each resident. The facility average CMI shall be computed as the standardized days divided by total days for all residents in the facility. The RUG's weights used in this section shall be as follows for each RUG's class: SE3 1.605; SE2 1.247; SE1 1.081; RAD 1.509; RAC 1.259; RAB 1.109; RAA 0.957; SSC 1.453; SSB 1.224; SSA 1.047; CC2 1.292; CC1 1.200; CB2 1.086; CB1 1.017; CA2 0.908; CA1 0.834; IB2 0.877; IB1 0.817; IA2 0.720; IA1 0.676; BB2 0.956; BB1 0.885; BA2 0.716; BA1 0.673; PE2 1.199; PE1 1.104; PD2 1.023; PD1 0.948; PC2 0.926; PC1 0.860; PB2 0.786; PB1 0.734; PA2 0.691; PA1 0.651; BC1 0.651; and DDF 1.000.

Subd. 14a. **Facility type groups.** Facilities shall be classified into two groups, called "facility type groups," which shall consist of:

(1) C&NC/R80: facilities that are hospital–attached, or are licensed under Minnesota Rules, parts 9570.2000 to 9570.3400; and

(2) freestanding: all other facilities.

[For text of subd 15, see M.S.2006]

Subd. 16. [Repealed, 2007 c 147 art 7 s 76]

Subd. 17. **Fringe benefit costs.** "Fringe benefit costs" means the costs for group life, health, dental, workers' compensation, and other employee insurances and pension, profit–sharing, and retirement plans for which the employer pays all or a portion of the costs.

[For text of subds 18 and 19, see M.S.2006]

Subd. 20. **Housekeeping costs.** "Housekeeping costs" means the costs for the salaries and wages of the housekeeping supervisor, housekeepers, and other cleaning employees and associated fringe benefits and payroll taxes. It also includes the cost of housekeeping supplies, including, but not limited to, cleaning and lavatory supplies and contract services.

Subd. 21. [Repealed, 2007 c 147 art 7 s 76]

[For text of subds 22 and 23, see M.S.2006]

Subd. 24. **Maintenance and plant operations costs.** "Maintenance and plant operations costs" means the costs for the salaries and wages of the maintenance supervisor, engi-

neers, heating–plant employees, and other maintenance employees and associated fringe benefits and payroll taxes. It also includes direct costs for maintenance and operation of the building and grounds, including, but not limited to, fuel, electricity, medical waste and garbage removal, water, sewer, supplies, tools, and repairs.

[For text of subd 25, see M.S.2006]

Subd. 26. [Repealed, 2007 c 147 art 7 s 76]

[For text of subd 27, see M.S.2006]

Subd. 28. [Repealed, 2007 c 147 art 7 s 76]

Subd. 28a. **Other direct care costs.** "Other direct care costs" means the costs for the salaries and wages and associated fringe benefits and payroll taxes of mental health workers, religious personnel, and other direct care employees not specified in the definition of direct care costs.

[For text of subd 29, see M.S.2006]

Subd. 30. **Peer groups.** Facilities shall be classified into three groups by county. The groups shall consist of:

(1) group one: facilities in Anoka, Benton, Carlton, Carver, Chisago, Dakota, Dodge, Goodhue, Hennepin, Isanti, Mille Lacs, Morrison, Olmsted, Ramsey, Rice, Scott, Sherburne, St. Louis, Stearns, Steele, Wabasha, Washington, Winona, or Wright County;

(2) group two: facilities in Aitkin, Beltrami, Blue Earth, Brown, Cass, Clay, Cook, Crow Wing, Faribault, Fillmore, Freeborn, Houston, Hubbard, Itasca, Kanabec, Koochiching, Lake, Lake of the Woods, Le Sueur, Martin, McLeod, Meeker, Mower, Nicollet, Norman, Pine, Roseau, Sibley, Todd, Wadena, Waseca, Watonwan, or Wilkin County; and

(3) group three: facilities in all other counties.

Subd. 31. **Prior system operating cost payment rate.** "Prior system operating cost payment rate" means the operating cost payment rate in effect on September 30, 2008, under Minnesota Rules and Minnesota Statutes, not including planned closure rate adjustments under section 256B.436 or 256B.437, or single bed room incentives under section 256B.431, subdivision 42.

[For text of subds 32 and 33, see M.S.2006]

Subd. 33a. **Raw food costs.** "Raw food costs" means the cost of food provided to nursing facility residents. Also included are special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet.

Subd. 34. **Related organization.** "Related organization" means a person that furnishes goods or services to a nursing facility and that is a close relative of a nursing facility, an affiliate of a nursing facility, a close relative of an affiliate of a nursing facility, or an affiliate of a close relative of an affiliate of a nursing facility. As used in this subdivision, paragraphs (a) to (d) apply:

(a) "Affiliate" means a person that directly, or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with another person.

(b) "Person" means an individual, a corporation, a partnership, an association, a trust, an unincorporated organization, or a government or political subdivision.

(c) "Close relative of an affiliate of a nursing facility" means an individual whose relationship by blood, marriage, or adoption to an individual who is an affiliate of a nursing facility is no more remote than first cousin.

(d) "Control" including the terms "controlling," "controlled by," and "under common control with" means the possession, direct or indirect, of the power to direct or cause the direction of the management, operations, or policies of a person, whether through the ownership of voting securities, by contract, or otherwise.

[For text of subds 35 to 37, see M.S.2006]

Subd. 38. **Social services costs.** "Social services costs" means the costs for the salaries and wages of the supervisor and other social work employees, associated fringe benefits and payroll taxes, supplies, services, and consultants. This category includes the cost of those employees who manage and process admission to the nursing facility.

[For text of subds 39 to 41, see M.S.2006]

Subd. 42. [Repealed, 2007 c 147 art 7 s 76]

Subd. 42a. **Therapy costs.** "Therapy costs" means any costs related to medical assistance therapy services provided to residents that are not billed separately from the daily operating rate.

[For text of subds 43 and 44, see M.S.2006]

Subd. 45. [Repealed, 2007 c 147 art 7 s 76]

[For text of subd 46, see M.S.2006]

Subd. 46a. **Calculation of quality add–on for the rate year beginning October 1, 2007.** (a) The payment rate for the rate year beginning October 1, 2007, for the quality add–on, is a variable amount based on each facility's quality score. For the rate year, the maximum quality add–on is .3 percent of the operating payment rate in effect on September 30, 2007. The commissioner shall determine the quality add–on for each facility according to paragraphs (b) to (d).

(b) For each facility, the commissioner shall determine the operating payment rate in effect on September 30, 2007.

(c) For each facility, the commissioner shall determine a ratio of the quality score of the facility determined in subdivision 44, subtract 40, and then divide by 60. If this value is less than zero, the commissioner shall use the value zero.

(d) For each facility, the quality add–on is the value determined in paragraph (b), multiplied by the value determined in paragraph (c), multiplied by .3 percent.

[For text of subd 47, see M.S.2006]

Subd. 48. **Calculation of operating per diems.** The direct care per diem for each facility shall be the facility's direct care costs divided by its standardized days. The other care–related per diem shall be the sum of the facility's activities costs, other direct care costs, raw food costs, therapy costs, and social services costs, divided by the facility's resident days. The other operating per diem shall be the sum of the facility's administrative costs, dietary costs, housekeeping costs, laundry costs, and maintenance and plant operations costs divided by the facility's resident days.

Subd. 49. **Determination of total care–related per diem.** The total care–related per diem for each facility shall be the sum of the direct care per diem and the other care–related per diem.

Subd. 50. **Determination of total care–related limit.** (a) The limit on the total care–related per diem shall be determined for each peer group and facility type group combination. A facility's total care–related per diems shall be limited to 120 percent of the median for the facility's peer and facility type group. The facility–specific direct care costs used in making this comparison and in the calculation of the median shall be based on a RUG's weight of 1.00. A facility that is above that limit shall have its total care–related per diem reduced to the limit. If a reduction of the total care–related per diem is necessary because of this limit, the reduction shall be made proportionally to both the direct care per diem and the other care–related per diem.

(b) Beginning with rates determined for October 1, 2016, the total care–related limit shall be a variable amount based on each facility's quality score, as determined under section 256B.441, subdivision 44, in accordance with clauses (1) to (4):

(1) for each facility, the commissioner shall determine the quality score, subtract 40, divide by 40, and convert to a percentage;

(2) if the value determined in clause (1) is less than zero, the total care–related limit shall be 105 percent of the median for the facility's peer and facility type group;

(3) if the value determined in clause (1) is greater than 100 percent, the total care–related limit shall be 125 percent of the median for the facility's peer and facility type group; and

(4) if the value determined in clause (1) is greater than zero and less than 100 percent, the total care–related limit shall be 105 percent of the median for the facility's peer and facility type group plus one–fifth of the percentage determined in clause (1).

Subd. 50a. **Determination of proximity adjustments.** For a nursing facility located in close proximity to another nursing facility of the same facility group type but in a different peer group and that has higher limits for care–related or other operating costs, the commissioner shall adjust the limits in accordance with clauses (1) to (4):

(1) determine the difference between the limits;

(2) determine the distance between the two facilities, by the shortest driving route. If the distance exceeds 20 miles, no adjustment shall be made;

(3) subtract the value in clause (2) from 20 miles, divide by 20, and convert to a percentage; and

(4) increase the limits for the nursing facility with the lower limits by the value determined in clause (1) multiplied by the value determined in clause (3).

Subd. 51. **Determination of other operating limit.** The limit on the other operating per diem shall be determined for each peer group. A facility's other operating per diem shall be limited to 105 percent of the median for its peer group. A facility that is above that limit shall have its other operating per diem reduced to the limit.

Subd. 51a. **Exception allowing contracting for specialized care.** (a) For rate years beginning on or after October 1, 2016, the commissioner may negotiate increases to the care–related limit for nursing facilities that provide specialized care, at a cost to the general fund not to exceed $600,000 per year. The commissioner shall publish a request for proposals annually, and may negotiate increases to the limits that shall apply for either one or two years before the increase shall be subject to a new proposal and negotiation. The care–related limit may be increased by up to 50 percent.

(b) In selecting facilities with which to negotiate, the commissioner shall consider:

(1) the diagnoses or other circumstances of residents in the specialized program that require care that costs substantially more than the RUG's rates associated with those residents;

(2) the nature of the specialized program or programs offered to meet the needs of these individuals; and

(3) outcomes achieved by the specialized program.

Subd. 52. **Determination of efficiency incentive.** Each facility shall be eligible for an efficiency incentive based on its other operating per diem. A facility with an other operating per diem that exceeds the limit in subdivision 51 shall receive no efficiency incentive. All other facilities shall receive an incentive calculated as 50 percent times the difference between the facility's other operating per diem and its other operating per diem limit, up to a maximum incentive of $3.

Subd. 53. **Calculation of payment rate for external fixed costs.** The commissioner shall calculate a payment rate for external fixed costs.

(a) For a facility licensed as a nursing home, the portion related to section 256.9657shall be equal to $8.86. For a facility licensed as both a nursing home and a boarding care home, the portion related to section 256.9657 shall be equal to $8.86 multiplied by the result of its number of nursing home beds divided by its total number of licensed beds.

(b) The portion related to the licensure fee under section 144.122, paragraph (d), shall be the amount of the fee divided by actual resident days.

(c) The portion related to scholarships shall be determined under section 256B.431, subdivision 36.

(d) The portion related to long–term care consultation shall be determined according to section 256B.0911, subdivision 6.

(e) The portion related to development and education of resident and family advisory councils under section 144A.33 shall be $5 divided by 365.

(f) The portion related to planned closure rate adjustments shall be as determined under sections 256B.436 and 256B.437, subdivision 6. Planned closure rate adjustments that take effect before October 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning October 1, 2016. Planned closure rate adjustments that take effect on or after October 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning on October 1 of the first year not less than two years after their effective date.

(g) The portions related to property insurance, real estate taxes, special assessments, and payments made in lieu of real estate taxes directly identified or allocated to the nursing facility shall be the actual amounts divided by actual resident days.

(h) The portion related to the Public Employees Retirement Association shall be actual costs divided by resident days.

(i) The single bed room incentives shall be as determined under section 256B.431, subdivision 42. Single bed room incentives that take effect before October 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning October 1, 2016. Single bed room incentives that take effect on or after October 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning on October 1 of the first year not less than two years after their effective date.

(j) The payment rate for external fixed costs shall be the sum of the amounts in paragraphs (a) to (i).

Subd. 54. **Determination of total payment rates.** In rate years when rates are rebased, the total payment rate for a RUG's weight of 1.00 shall be the sum of the total care–related payment rate, other operating payment rate, efficiency incentive, external fixed cost rate, and the property rate determined under section 256B.434. To determine a total payment rate for each RUG's level, the total care–related payment rate shall be divided into the direct care payment rate and the other care–related payment rate, and the direct care payment rate multiplied by the RUG's weight for each RUG's level using the weights in subdivision 14.

Subd. 55. **Phase–in of rebased operating cost payment rates.** (a) For the rate years beginning October 1, 2008, to October 1, 2012, the operating cost payment rate calculated under this section shall be phased in by blending the operating cost rate with the operating cost payment rate determined under section 256B.434. For the rate year beginning October 1, 2008, the operating cost payment rate for each facility shall be 13 percent of the operating cost payment rate from this section, and 87 percent of the operating cost payment rate from section 256B.434. For the rate year beginning October 1, 2009, the operating cost payment rate for each facility shall be 14 percent of the operating cost payment rate from this section, and 86 percent of the operating cost payment rate from section 256B.434. For the rate year beginning October 1, 2010, the operating cost payment rate for each facility shall be 14 percent of the operating cost payment rate from this section, and 86 percent of the operating cost payment rate from section 256B.434. For the rate year beginning October 1, 2011, the operating cost payment rate for each facility shall be 31 percent of the operating cost payment rate from this section, and 69 percent of the operating cost payment rate from section 256B.434. For the rate year beginning October 1, 2012, the operating cost payment rate for each facility shall be 48 percent of the operating cost payment rate from this section, and 52 percent of the operating cost payment rate from section 256B.434. For the rate year beginning October 1, 2013, the operating cost payment rate for each facility shall be 65 percent of the operating cost payment rate from this section, and 35 percent of the operating cost payment rate from section 256B.434. For the rate year beginning October 1, 2014, the operating cost payment rate for each facility shall be 82 percent of the operating cost payment rate from this section, and 18 percent of the operating cost payment rate from section 256B.434. For the rate year

beginning October 1, 2015, the operating cost payment rate for each facility shall be the operating cost payment rate determined under this section. The blending of operating cost payment rates under this section shall be performed separately for each RUG's class.

(b) A portion of the funds received under this subdivision that are in excess of operating cost payment rates that a facility would have received under section 256B.434, as determined in accordance with clauses (1) to (3), shall be subject to the requirements in section 256B.434, subdivision 19, paragraphs (b) to (h).

(1) Determine the amount of additional funding available to a facility, which shall be equal to total medical assistance resident days from the most recent reporting year times the difference between the blended rate determined in paragraph (a) for the rate year being computed and the blended rate for the prior year.

(2) Determine the portion of all operating costs, for the most recent reporting year, that are compensation related. If this value exceeds 75 percent, use 75 percent.

(3) Subtract the amount determined in clause (2) from 75 percent.

(4) The portion of the fund received under this subdivision that shall be subject to the requirements in section 256B.434, subdivision 19, paragraphs (b) to (h), shall equal the amount determined in clause (1) times the amount determined in clause (3).

Subd. 56. **Hold harmless.** For the rate years beginning October 1, 2008, to October 1, 2016, no nursing facility shall receive an operating cost payment rate less than its operating cost payment rate under section 256B.434. The comparison of operating cost payment rates under this section shall be made for a RUG's rate with a weight of 1.00.

Subd. 57. **Appeals.** Nursing facilities may appeal, as described under section 256B.50, the determination of a payment rate established under this chapter.

Subd. 58. **Implementation delay.** Within six months prior to the effective date of (1) rebasing of property payment rates under subdivision 1; (2) quality–based rate limits under subdivision 50; and (3) the removal of planned closure rate adjustments and single bed room incentives from external fixed costs under subdivision 53, the commissioner shall compare the average operating cost for all facilities combined from the most recent cost reports to the average medical assistance operating payment rates for all facilities combined from the same time period. Each provision shall not go into effect until the average medical assistance operating payment rate is at least 92 percent of the average operating cost.

History: *2007 c 147 art 7 s 25–57*

256B.49 HOME AND COMMUNITY–BASED SERVICE WAIVERS FOR DISABLED.

Subd. 11. **Authority.** (a) The commissioner is authorized to apply for home and community–based service waivers, as authorized under section 1915(c) of the Social Security Act to serve persons under the age of 65 who are determined to require the level of care provided in a nursing home and persons who require the level of care provided in a hospital. The commissioner shall apply for the home and community–based waivers in order to:

(i) promote the support of persons with disabilities in the most integrated settings;

(ii) expand the availability of services for persons who are eligible for medical assistance;

(iii) promote cost–effective options to institutional care; and

(iv) obtain federal financial participation.

(b) The provision of waivered services to medical assistance recipients with disabilities shall comply with the requirements outlined in the federally approved applications for home and community–based services and subsequent amendments, including provision of services according to a service plan designed to meet the needs of the individual. For purposes of this section, the approved home and community–based application is considered the necessary federal requirement.

(c) The commissioner shall provide interested persons serving on agency advisory committees, task forces, the Centers for Independent Living, and others who request to be on

a list to receive, notice of, and an opportunity to comment on, at least 30 days before any effective dates, (1) any substantive changes to the state's disability services program manual, or (2) changes or amendments to the federally approved applications for home and community–based waivers, prior to their submission to the federal Centers for Medicare and Medicaid Services.

(d) The commissioner shall seek approval, as authorized under section 1915(c) of the Social Security Act, to allow medical assistance eligibility under this section for children under age 21 without deeming of parental income or assets.

(e) The commissioner shall seek approval, as authorized under section 1915(c) of the Social Act, to allow medical assistance eligibility under this section for individuals under age 65 without deeming the spouse's income or assets.

[For text of subds 12 to 16, see M.S.2006]

Subd. 16a. **Medical assistance reimbursement.** (a) The commissioner shall seek federal approval for medical assistance reimbursement of independent living skills services, foster care waiver service, supported employment, prevocational service, structured day service, and adult day care under the home and community–based waiver for persons with a traumatic brain injury, the community alternatives for disabled individuals waivers, and the community alternative care waivers.

(b) Medical reimbursement shall be made only when the provider demonstrates evidence of its capacity to meet basic health, safety, and protection standards through one of the methods in paragraphs (c) to (e).

(c) The provider is licensed to provide services under chapter 245B and agrees to apply these standards to services funded through the traumatic brain injury, community alternatives for disabled, or community alternative care home and community–based waivers.

(d) The local agency contracting for the services certifies on a form provided by the commissioner that the provider has the capacity to meet the individual needs as identified in each person's individual service plan. When certifying that the service provider meets the necessary provider qualifications, the local agency shall verify that the provider has policies and procedures governing the following:

(1) protection of the consumer's rights and privacy;

(2) risk assessment and planning;

(3) record keeping and reporting of incidents and emergencies with documentation of corrective action if needed;

(4) service outcomes, regular reviews of progress, and periodic reports;

(5) complaint and grievance procedures;

(6) service termination or suspension;

(7) necessary training and supervision of direct care staff that includes:

(i) documentation in personnel files of 20 hours of orientation training in providing training related to service provision;

(ii) training in recognizing the symptoms and effects of certain disabilities, health conditions, and positive behavioral supports and interventions;

(iii) a minimum of five hours of related training annually; and

(iv) when applicable:

(A) safe medication administration;

(B) proper handling of consumer funds; and

(C) compliance with prohibitions and standards developed by the commissioner to satisfy federal requirements regarding the use of restraints and restrictive interventions. The local agency shall review at least annually each service provider's continued compliance with the standards governing basic health, safety, and protection of rights.

(c) The commissioner shall seek federal approval for Medicaid reimbursement of foster care services under the home and community–based waiver for persons with a traumatic

brain injury, the community alternatives for disabled individuals waiver, and community alternative care waiver when the provider demonstrates evidence of its capacity to meet basic health, safety, and protection standards. The local agency shall verify that the provider is licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, and certify that the provider has policies and procedures that govern:

(1) compliance with prohibitions and standards developed by the commissioner to meet federal requirements regarding the use of restraints and restrictive interventions; and

(2) documentation of service needs and outcomes, regular reviews of progress, and periodic reports.

The local agency shall review at least annually each service provider's continued compliance with the standards governing basic health, safety, and protection of rights standards.

[For text of subds 17 to 21, see M.S.2006]

History: *2007 c 147 art 6 s 45; art 7 s 58*

256B.5012 ICF/MR PAYMENT SYSTEM IMPLEMENTATION.

[For text of subds 1 to 6, see M.S.2006]

Subd. 7. **ICF/MR rate increases effective October 1, 2007, and October 1, 2008.** (a) For the rate year beginning October 1, 2007, the commissioner shall make available to each facility reimbursed under this section operating payment rate adjustments equal to 2.0 percent of the operating payment rates in effect on September 30, 2007. For the rate year beginning July 1, 2008, the commissioner shall make available to each facility reimbursed under this section operating payment rate adjustments equal to 2.0 percent of the operating payment rates in effect on June 30, 2008. For each facility, the commissioner shall make available an adjustment, based on occupied beds, using the percentage specified in this paragraph multiplied by the total payment rate, including the variable rate but excluding the property–related payment rate, in effect on the preceding day. The total payment rate shall include the adjustment provided in section 256B.501, subdivision 12. A facility whose payment rates are governed by closure agreements, receivership agreements, or Minnesota Rules, part 9553.0075, is not eligible for an adjustment otherwise granted under this subdivision.

(b) Seventy–five percent of the money resulting from the rate adjustments under paragraph (a) must be used for increases in compensation–related costs for employees directly employed by the facility on or after the effective date of the rate adjustments, except:

(1) the administrator;

(2) persons employed in the central office of a corporation that has an ownership interest in the facility or exercises control over the facility; and

(3) persons paid by the facility under a management contract.

(c) Two–thirds of the money available under paragraph (b) must be used for wage increases for all employees directly employed by the facility on or after the effective date of the rate adjustments, except those listed in paragraph (b), clauses (1) to (3). The wage adjustment that employees receive under this paragraph must be paid as an equal hourly percentage wage increase for all eligible employees. All wage increases under this paragraph must be effective on the same date. Only costs associated with the portion of the equal hourly percentage wage increase that goes to all employees shall qualify under this paragraph. Costs associated with wage increases in excess of the amount of the equal hourly percentage wage increase provided to all employees shall be allowed only for meeting the requirements in paragraph (b). This paragraph shall not apply to employees covered by a collective bargaining agreement.

(d) The commissioner shall allow as compensation–related costs all costs for:

(1) wages and salaries;

(2) FICA taxes, Medicare taxes, state and federal unemployment taxes, and workers' compensation;

(3) the employer's share of health and dental insurance, life insurance, disability insurance, long–term care insurance, uniform allowance, and pensions; and

(4) other benefits provided, subject to the approval of the commissioner.

(e) The portion of the rate adjustments under paragraph (a) that is not subject to the requirements in paragraphs (b) and (c) shall be provided to facilities effective October 1 of each year.

(f) Facilities may apply for the portion of the rate adjustments under paragraph (a) that is subject to the requirements in paragraphs (b) and (c). The application must be submitted to the commissioner within six months of the effective date of the rate adjustments, and the facility must provide additional information required by the commissioner within nine months of the effective date of the rate adjustments. The commissioner must respond to all applications within three weeks of receipt. The commissioner may waive the deadlines in this paragraph under extraordinary circumstances, to be determined at the sole discretion of the commissioner. The application must contain:

(1) an estimate of the amounts of money that must be used as specified in paragraphs (b) and (c);

(2) a detailed distribution plan specifying the allowable compensation–related and wage increases the facility will implement to use the funds available in clause (1);

(3) a description of how the facility will notify eligible employees of the contents of the approved application, which must provide for giving each eligible employee a copy of the approved application, excluding the information required in clause (1), or posting a copy of the approved application, excluding the information required in clause (1), for a period of at least six weeks in an area of the facility to which all eligible employees have access; and

(4) instructions for employees who believe they have not received the compensation–related or wage increases specified in clause (2), as approved by the commissioner, and which must include a mailing address, e–mail address, and the telephone number that may be used by the employee to contact the commissioner or the commissioner's representative.

(g) The commissioner shall ensure that cost increases in distribution plans under paragraph (f), clause (2), that may be included in approved applications, comply with requirements in clauses (1) to (4):

(1) costs to be incurred during the applicable rate year resulting from wage and salary increases effective after October 1, 2006, and prior to the first day of the facility's payroll period that includes October 1 of each year shall be allowed if they were not used in the prior year's application and they meet the requirements of paragraphs (b) and (c);

(2) a portion of the costs resulting from tenure–related wage or salary increases may be considered to be allowable wage increases, according to formulas that the commissioner shall provide, where employee retention is above the average statewide rate of retention of direct care employees;

(3) the annualized amount of increases in costs for the employer's share of health and dental insurance, life insurance, disability insurance, and workers' compensation shall be allowable compensation–related increases if they are effective on or after April 1 of the year in which the rate adjustments are effective and prior to April 1 of the following year; and

(4) for facilities in which employees are represented by an exclusive bargaining representative, the commissioner shall approve the application only upon receipt of a letter of acceptance of the distribution plan, as regards members of the bargaining unit, signed by the exclusive bargaining agent and dated after May 25, 2007. Upon receipt of the letter of acceptance, the commissioner shall deem all requirements of this section as having been met in regard to the members of the bargaining unit.

(h) The commissioner shall review applications received under paragraph (f) and shall provide the portion of the rate adjustments under paragraphs (b) and (c) if the requirements of this subdivision have been met. The rate adjustments shall be effective October 1 of each year. Notwithstanding paragraph (a), if the approved application distributes less money than

is available, the amount of the rate adjustment shall be reduced so that the amount of money made available is equal to the amount to be distributed.

History: *2007 c 147 art 7 s 59*

256B.69 PREPAYMENT DEMONSTRATION PROJECT.

[For text of subds 1 to 3b, see M.S.2006]

Subd. 4. **Limitation of choice.** (a) The commissioner shall develop criteria to determine when limitation of choice may be implemented in the experimental counties. The criteria shall ensure that all eligible individuals in the county have continuing access to the full range of medical assistance services as specified in subdivision 6.

(b) The commissioner shall exempt the following persons from participation in the project, in addition to those who do not meet the criteria for limitation of choice:

(1) persons eligible for medical assistance according to section 256B.055, subdivision 1;

(2) persons eligible for medical assistance due to blindness or disability as determined by the Social Security Administration or the state medical review team, unless:

(i) they are 65 years of age or older; or

(ii) they reside in Itasca County or they reside in a county in which the commissioner conducts a pilot project under a waiver granted pursuant to section 1115 of the Social Security Act;

(3) recipients who currently have private coverage through a health maintenance organization;

(4) recipients who are eligible for medical assistance by spending down excess income for medical expenses other than the nursing facility per diem expense;

(5) recipients who receive benefits under the Refugee Assistance Program, established under United States Code, title 8, section 1522(e);

(6) children who are both determined to be severely emotionally disturbed and receiving case management services according to section 256B.0625, subdivision 20, except children who are eligible for and who decline enrollment in an approved preferred integrated network under section 245.4682;

(7) adults who are both determined to be seriously and persistently mentally ill and received case management services according to section 256B.0625, subdivision 20;

(8) persons eligible for medical assistance according to section 256B.057, subdivision 10; and

(9) persons with access to cost–effective employer–sponsored private health insurance or persons enrolled in a non–Medicare individual health plan determined to be cost–effective according to section 256B.0625, subdivision 15.

Children under age 21 who are in foster placement may enroll in the project on an elective basis. Individuals excluded under clauses (1), (6), and (7) may choose to enroll on an elective basis. The commissioner may enroll recipients in the prepaid medical assistance program for seniors who are (1) age 65 and over, and (2) eligible for medical assistance by spending down excess income.

(c) The commissioner may allow persons with a one–month spenddown who are otherwise eligible to enroll to voluntarily enroll or remain enrolled, if they elect to prepay their monthly spenddown to the state.

(d) The commissioner may require those individuals to enroll in the prepaid medical assistance program who otherwise would have been excluded under paragraph (b), clauses (1), (3), and (8), and under Minnesota Rules, part 9500.1452, subpart 2, items H, K, and L.

(e) Before limitation of choice is implemented, eligible individuals shall be notified and after notification, shall be allowed to choose only among demonstration providers. The commissioner may assign an individual with private coverage through a health maintenance or-

ganization, to the same health maintenance organization for medical assistance coverage, if the health maintenance organization is under contract for medical assistance in the individual's county of residence. After initially choosing a provider, the recipient is allowed to change that choice only at specified times as allowed by the commissioner. If a demonstration provider ends participation in the project for any reason, a recipient enrolled with that provider must select a new provider but may change providers without cause once more within the first 60 days after enrollment with the second provider.

(f) An infant born to a woman who is eligible for and receiving medical assistance and who is enrolled in the prepaid medical assistance program shall be retroactively enrolled to the month of birth in the same managed care plan as the mother once the child is enrolled in medical assistance unless the child is determined to be excluded from enrollment in a prepaid plan under this section.

[For text of subds 4b to 5f, see M.S.2006]

Subd. 5g. **Payment for covered services.** For services rendered on or after January 1, 2003, the total payment made to managed care plans for providing covered services under the medical assistance and general assistance medical care programs is reduced by .5 percent from their current statutory rates. This provision excludes payments for nursing home services, home and community–based waivers, payments to demonstration projects for persons with disabilities, and mental health services added as covered benefits after December 31, 2007.

Subd. 5h. **Payment reduction.** In addition to the reduction in subdivision 5g, the total payment made to managed care plans under the medical assistance program is reduced 1.0 percent for services provided on or after October 1, 2003, and an additional 1.0 percent for services provided on or after January 1, 2004. This provision excludes payments for nursing home services, home and community–based waivers, payments to demonstration projects for persons with disabilities, and mental health services added as covered benefits after December 31, 2007.

[For text of subds 6 to 22, see M.S.2006]

Subd. 23. **Alternative 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 persons and persons with disabilities as defined in section 256B.77, subdivision 7a, that provide increased coordination, improve access to quality services, and mitigate future cost increases. The commissioner may seek federal authority to combine Medicare and Medicaid capitation payments for the purpose of such demonstrations and may contract with Medicare–approved special needs plans to provide Medicaid services. Medicare funds and services shall be administered according to the terms and conditions of the federal contract and demonstration provisions. For the purpose of administering medical assistance funds, demonstrations under this subdivision are subject to subdivisions 1 to 22. The provisions of Minnesota Rules, parts 9500.1450 to 9500.1464, apply to these demonstrations, with the exceptions of parts 9500.1452, subpart 2, item B; and 9500.1457, subpart 1, items B and C, which do not apply to persons enrolling in demonstrations under this section. An initial open enrollment period may be provided. Persons who disenroll from demonstrations under this subdivision remain subject to Minnesota Rules, parts 9500.1450 to 9500.1464. When a person is enrolled in a health plan under these demonstrations and the health plan's participation is subsequently terminated for any reason, the person shall be provided an opportunity to select a new health plan and shall have the right to change health plans within the first 60 days of enrollment in the second health plan. Persons required to participate in health plans under this section who fail to make a choice of health plan shall not be randomly assigned to health plans under these demonstrations. Notwithstanding section 256L.12, subdivision 5, and Minnesota Rules, part 9505.5220, subpart 1, item A, if adopted, for the purpose of demonstrations under this subdivision, the commissioner may contract with managed care organizations, including counties, to serve only el-

derly persons eligible for medical assistance, elderly and disabled persons, or disabled persons only. For persons with a primary diagnosis of developmental disability, serious and persistent mental illness, or serious emotional disturbance, the commissioner must ensure that the county authority has approved the demonstration and contracting design. Enrollment in these projects for persons with disabilities shall be voluntary. The commissioner shall not implement any demonstration project under this subdivision for persons with a primary diagnosis of developmental disabilities, serious and persistent mental illness, or serious emotional disturbance, without approval of the county board of the county in which the demonstration is being implemented.

(b) Notwithstanding chapter 245B, sections 252.40 to 252.46, 256B.092, 256B.501 to 256B.5015, and Minnesota Rules, parts 9525.0004 to 9525.0036, 9525.1200 to 9525.1330, 9525.1580, and 9525.1800 to 9525.1930, the commissioner may implement under this section projects for persons with developmental disabilities. The commissioner may capitate payments for ICF/MR services, waivered services for developmental disabilities, including case management services, day training and habilitation and alternative active treatment services, and other services as approved by the state and by the federal government. Case management and active treatment must be individualized and developed in accordance with a person–centered plan. Costs under these projects may not exceed costs that would have been incurred under fee–for–service. Beginning July 1, 2003, and until four years after the pilot project implementation date, subcontractor participation in the long–term care developmental disability pilot is limited to a nonprofit long–term care system providing ICF/MR services, home and community–based waiver services, and in–home services to no more than 120 consumers with developmental disabilities in Carver, Hennepin, and Scott Counties. The commissioner shall report to the legislature prior to expansion of the developmental disability pilot project. This paragraph expires four years after the implementation date of the pilot project.

(c) 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.

(d) A nursing facility reimbursed under the alternative reimbursement methodology in section 256B.434 may, in collaboration with a hospital, clinic, or other health care entity provide services under paragraph (a). The commissioner shall amend the state plan and seek any federal waivers necessary to implement this paragraph.

(e) The commissioner, in consultation with the commissioners of commerce and health, may approve and implement programs for all–inclusive care for the elderly (PACE) according to federal laws and regulations governing that program and state laws or rules applicable to participating providers. The process for approval of these programs shall begin only after the commissioner receives grant money in an amount sufficient to cover the state share of the administrative and actuarial costs to implement the programs during state fiscal years 2006 and 2007. Grant amounts for this purpose shall be deposited in an account in the special revenue fund and are appropriated to the commissioner to be used solely for the purpose of PACE administrative and actuarial costs. A PACE provider is not required to be licensed or certified as a health plan company as defined in section 62Q.01, subdivision 4. Persons age 55 and older who have been screened by the county and found to be eligible for services under the elderly waiver or community alternatives for disabled individuals or who are already eligible for Medicaid but meet level of care criteria for receipt of waiver services may choose to enroll in the PACE program. Medicare and Medicaid services will be provided according to this subdivision and federal Medicare and Medicaid requirements governing PACE providers and programs. PACE enrollees will receive Medicaid home and community–based services through the PACE provider as an alternative to services for which they would otherwise be eligible through home and community–based waiver programs and Medicaid State Plan Services. The commissioner shall establish Medicaid rates for PACE providers that do not ex-

ceed costs that would have been incurred under fee–for–service or other relevant managed care programs operated by the state.

(f) The commissioner shall seek federal approval to expand the Minnesota disability health options (MnDHO) program established under this subdivision in stages, first to regional population centers outside the seven–county metro area and then to all areas of the state. Until July 1, 2009, expansion for MnDHO projects that include home and community–based services is limited to the two projects and service areas in effect on March 1, 2006. Enrollment in integrated MnDHO programs that include home and community–based services shall remain voluntary. Costs for home and community–based services included under MnDHO must not exceed costs that would have been incurred under the fee–for–service program. In developing program specifications for expansion of integrated programs, the commissioner shall involve and consult the state–level stakeholder group established in subdivision 28, paragraph (d), including consultation on whether and how to include home and community–based waiver programs. Plans for further expansion of MnDHO projects shall be presented to the chairs of the house and senate committees with jurisdiction over health and human services policy and finance by February 1, 2007.

(g) Notwithstanding section 256B.0261, health plans providing services under this section are responsible for home care targeted case management and relocation targeted case management. Services must be provided according to the terms of the waivers and contracts approved by the federal government.

[For text of subds 24a to 28, see M.S.2006]

History: *2007 c 147 art 7 s 60; art 8 s 24–26*

NOTE: The amendment to subdivision 4 by Laws 2007, chapter 147, article 8, section 24, is effective January 1, 2009. Laws 2007, chapter 147, article 8, section 24, the effective date.

256B.76 PHYSICIAN AND DENTAL REIMBURSEMENT.

(a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for physician services as follows:

(1) payment for level one Centers for Medicare and Medicaid Services' common procedural coding system codes titled "office and other outpatient services," "preventive medicine new and established patient," "delivery, antepartum, and postpartum care," "critical care," cesarean delivery and pharmacologic management provided to psychiatric patients, and level three codes for enhanced services for prenatal high risk, shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992. If the rate on any procedure code within these categories is different than the rate that would have been paid under the methodology in section 256B.74, subdivision 2, then the larger rate shall be paid;

(2) payments for all other services shall be paid at the lower of (i) submitted charges, or (ii) 15.4 percent above the rate in effect on June 30, 1992;

(3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases except that payment rates for home health agency services shall be the rates in effect on September 30, 1992;

(4) effective for services rendered on or after January 1, 2000, payment rates for physician and professional services shall be increased by three percent over the rates in effect on December 31, 1999, except for home health agency and family planning agency services; and

(5) the increases in clause (4) shall be implemented January 1, 2000, for managed care.

(b) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for dental services as follows:

(1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992;

(2) dental rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases;

(3) effective for services rendered on or after January 1, 2000, payment rates for dental services shall be increased by three percent over the rates in effect on December 31, 1999;

(4) the commissioner shall award grants to community clinics or other nonprofit community organizations, political subdivisions, professional associations, or other organizations that demonstrate the ability to provide dental services effectively to public program recipients. Grants may be used to fund the costs related to coordinating access for recipients, developing and implementing patient care criteria, upgrading or establishing new facilities, acquiring furnishings or equipment, recruiting new providers, or other development costs that will improve access to dental care in a region. In awarding grants, the commissioner shall give priority to applicants that plan to serve areas of the state in which the number of dental providers is not currently sufficient to meet the needs of recipients of public programs or uninsured individuals. The commissioner shall consider the following in awarding the grants:

(i) potential to successfully increase access to an underserved population;

(ii) the ability to raise matching funds;

(iii) the long-term viability of the project to improve access beyond the period of initial funding;

(iv) the efficiency in the use of the funding; and

(v) the experience of the proposers in providing services to the target population.

The commissioner shall monitor the grants and may terminate a grant if the grantee does not increase dental access for public program recipients. The commissioner shall consider grants for the following:

(i) implementation of new programs or continued expansion of current access programs that have demonstrated success in providing dental services in underserved areas;

(ii) a pilot program for utilizing hygienists outside of a traditional dental office to provide dental hygiene services; and

(iii) a program that organizes a network of volunteer dentists, establishes a system to refer eligible individuals to volunteer dentists, and through that network provides donated dental care services to public program recipients or uninsured individuals;

(5) beginning October 1, 1999, the payment for tooth sealants and fluoride treatments shall be the lower of (i) submitted charge, or (ii) 80 percent of median 1997 charges;

(6) the increases listed in clauses (3) and (5) shall be implemented January 1, 2000, for managed care; and

(7) effective for services provided on or after January 1, 2002, payment for diagnostic examinations and dental x-rays provided to children under age 21 shall be the lower of (i) the submitted charge, or (ii) 85 percent of median 1999 charges.

(c) Effective for dental services rendered on or after January 1, 2002, the commissioner shall increase reimbursements to dentists and dental clinics deemed by the commissioner to be critical access dental providers. For dental services rendered on or after July 1, 2007, the commissioner shall increase reimbursement by 30 percent above the reimbursement rate that would otherwise be paid to the critical access dental provider. The commissioner shall pay the health plan companies in amounts sufficient to reflect increased reimbursements to critical access dental providers as approved by the commissioner. In determining which dentists and dental clinics shall be deemed critical access dental providers, the commissioner shall review:

(1) the utilization rate in the service area in which the dentist or dental clinic operates for dental services to patients covered by medical assistance, general assistance medical care, or MinnesotaCare as their primary source of coverage;

(2) the level of services provided by the dentist or dental clinic to patients covered by medical assistance, general assistance medical care, or MinnesotaCare as their primary source of coverage; and

(3) whether the level of services provided by the dentist or dental clinic is critical to maintaining adequate levels of patient access within the service area.

In the absence of a critical access dental provider in a service area, the commissioner may designate a dentist or dental clinic as a critical access dental provider if the dentist or dental clinic is willing to provide care to patients covered by medical assistance, general assistance medical care, or MinnesotaCare at a level which significantly increases access to dental care in the service area.

(d) An entity that operates both a Medicare certified comprehensive outpatient rehabilitation facility and a facility which was certified prior to January 1, 1993, that is licensed under Minnesota Rules, parts 9570.2000 to 9570.3600, and for whom at least 33 percent of the clients receiving rehabilitation services in the most recent calendar year are medical assistance recipients, shall be reimbursed by the commissioner for rehabilitation services at rates that are 38 percent greater than the maximum reimbursement rate allowed under paragraph (a), clause (2), when those services are (1) provided within the comprehensive outpatient rehabilitation facility and (2) provided to residents of nursing facilities owned by the entity.

(e) Effective for services rendered on or after January 1, 2007, the commissioner shall make payments for physician and professional services based on the Medicare relative value units (RVU's). This change shall be budget neutral and the cost of implementing RVU's will be incorporated in the established conversion factor.

History: *2007 c 147 art 5 s 14*

256B.763 CRITICAL ACCESS MENTAL HEALTH RATE INCREASE.

(a) For services defined in paragraph (b) and rendered on or after July 1, 2007, payment rates shall be increased by 23.7 percent over the rates in effect on January 1, 2006, for:

(1) psychiatrists and advanced practice registered nurses with a psychiatric specialty;

(2) community mental health centers under section 256B.0625, subdivision 5; and

(3) mental health clinics and centers certified under Minnesota Rules, parts 9520.0750 to 9520.0870, or hospital outpatient psychiatric departments that are designated as essential community providers under section 62Q.19.

(b) This increase applies to group skills training when provided as a component of children's therapeutic services and support, psychotherapy, medication management, evaluation and management, diagnostic assessment, explanation of findings, psychological testing, neuropsychological services, direction of behavioral aides, and inpatient consultation.

(c) This increase does not apply to rates that are governed by section 256B.0625, subdivision 30, or 256B.761, paragraph (b), other cost–based rates, rates that are negotiated with the county, rates that are established by the federal government, or rates that increased between January 1, 2004, and January 1, 2005.

(d) The commissioner shall adjust rates paid to prepaid health plans under contract with the commissioner to reflect the rate increases provided in paragraphs (a), (e), and (f). The prepaid health plan must pass this rate increase to the providers identified in paragraphs (a), (e), (f), and (g).

(e) Payment rates shall be increased by 23.7 percent over the rates in effect on December 31, 2007, for:

(1) medication education services provided on or after January 1, 2008, by adult rehabilitative mental health services providers certified under section 256B.0623; and

(2) mental health behavioral aide services provided on or after January 1, 2008, by children's therapeutic services and support providers certified under section 256B.0943.

(f) For services defined in paragraph (b) and rendered on or after January 1, 2008, by children's therapeutic services and support providers certified under section 256B.0943 and not already included in paragraph (a), payment rates shall be increased by 23.7 percent over the rates in effect on December 31, 2007.

(g) Payment rates shall be increased by 2.3 percent over the rates in effect on December 31, 2007, for individual and family skills training provided on or after January 1, 2008, by children's therapeutic services and support providers certified under section 256B.0943.

History: *2007 c 147 art 8 s 27*

256B.764 REIMBURSEMENT FOR FAMILY PLANNING SERVICES.

Effective for services rendered on or after July 1, 2007, payment rates for family planning services shall be increased by 25 percent over the rates in effect June 30, 2007, when these services are provided by a community clinic as defined in section 145.9268, subdivision 1.

History: *2007 c 147 art 5 s 15*

256B.77 COORDINATED SERVICE DELIVERY SYSTEM FOR DISABLED.

[For text of subds 1 to 22, see M.S.2006]

Subd. 23. [Repealed, 2007 c 133 art 2 s 13]

[For text of subds 25 to 27, see M.S.2006]